'The Soul of a Nation: A Social History of Disabled People, Physical Therapy, Rehabilitation and Sport in Britain 1918-1970'

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'The greatness of a nation is in its fit men, but the soul of a nation is revealed in its attitude to its unfortunates'

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Abstract

This work examines the role of physical therapy, rehabilitation and sport for disabled people in Britain in the period 1918-1970. Both remedial exercise and games for disabled people have a long history. Much of the therapy, both physical and medical was a product of wartime conditions and experiences. The First World War created a mass of disabled men, mainly young, who wished to recapture the spirit of their previous able-bodied lives. At Homes for disabled ex-servicemen, and in various support organisations, sport formed an important part of their lives, which in part helped them regain a feeling of normality.

The provision of therapy and sport was further evidence of a hierarchy of disability. The recognition of such a hierarchy forms a central part of this work. The hierarchy, which related to access to opportunities, facilities and support, placed disabled ex-servicemen at the top, followed by the industrial disabled and then civilians. The exception was disabled children, who were provided with physical therapy of varying quality, which was deemed to assist them in both their physical and moral development. The term rehabilitation was coined in the late 1930s in reference to an all-encompassing treatment that developed out of the work done mainly by the Armed Forces throughout the Second World War. The work will examine how rehabilitation became a central feature of the lives of disabled people. It was adopted for the spinal paralysed at the Spinal Unit of the Stoke Mandeville Hospital in Aylesbury during the war. Stoke Mandeville specifically, and the process of rehabilitation generally, proved an important catalyst for the steady emergence of organised

disabled sport in the post-1945 period. Throughout the 1950s activities for disabled people continued to flourish in various sectors, although it was on a small scale and disabled groups were isolated from one another. By the 1960s, as this work demonstrates, there were moves to integrate different disabled groups in the sporting area, and access to sporting facilities became part of the wider process of the politicisation of disabled people.

There is little empirical or historical work on the lives of disabled people in Britain. In using a wide range of archival sources drawn from both official records and from disabled organisations, this thesis will offer an original piece of research, which will cover the history one of Britain's largest, and yet little studied, 'minority' groups.

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I am eternally grateful to my long-suffering supervisor Professor Tony Mason who provided guidance, understanding, insight and illegible squiggles to this work. I am sure that he feels, quite correctly, that anything less than a gold medal would be insufficient.

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This thesis is dedicated to Mike Cronin, whose special ability is not just believing in me, but helping me to believe in myself.

Glossary of Terms

AIR	Air Ministry
BDSA	British Deaf Sporting Association
BLESMA	British Limbless Ex-servicemen's Association
BOE	Board of Education
BRCS	British Red Cross Society
BSAD	British Sports Association for the Disabled
CAB	Cabinet Papers
CCPR	Central Council for Physical Recreation
CMAC	Contemporary Medical Archive Collection
CO	Colonial Office
DIG	Disablement Income Group
DRO	Disablement Resettlement Officer
ED	Ministry of Education
FD	Medical Research Council
FO	Foreign Office
IOC	International Olympic Committee
IWM	Imperial War Museum
LAB	Ministry of Labour
MH	Ministry of Health
PEA	Physical Education Association
PIN	Ministry of Pensions
POSSUM	Patient Operated Selector Mechanism
PRO	Public Record Office

RNIB	Royal National Institute for the Blind
RNID	Royal National Institute for Deaf People

CONTENTS

Introduction

Disablement can be a result of many situations, such as birth defects, war, working in industry, poor health care and poverty. Although disabled people have always been a part of society, throughout the twentieth century, large-scale conflicts, a low standard of health provision, numbers of poor people, and unsafe industry increased numbers of disabled people at specific points during the century. Even in times of peace, improved medical care has prevented certain death or prolonged the lives of disabled people but has not always led to improved life chances. Disabled people form approximately ten percent of Britain's population yet their history has been ignored.

By contrast, other minorities are well represented in historical works. There have been studies for example, of race and gender in Britain and beyond. Whilst these minorities have developed written histories, have journals which concentrate specifically on their study and are the themes for scholarly conferences, the history of disabled people has largely been overlooked by the historical profession.

That is not to say however, that disabled people have not been the focus of certain types of study. In the field of public policy, disabled people have been strongly represented by writers such as Colin Barnes and Michael Oliver.[1] Their books generally deal with the subject of disability politics, and they explain the

rise of groups representing the disabled and the changing meanings of disability. While there is a basic history evident in their publications they rarely take a detailed view, as they largely concentrate on the history of the political disability movement from the 1960s. Insofar as they do delve into the history of disabled people, the result has been superficial, only relating the history of disabled people to their marginalisation within wider society. There is, according to those researching in the public policy field, a reason for this. Jane Campbell and Michael Oliver's *Disability Politics* argued that the study of the history of disabled people was not 'feasible' as their life experiences had been too neglected.[2] As they see it, the use of personal experience is the only way to write a history of disabled people.

With this mind, the reasons for researching the history of disabled people in twentieth century Britain become clearer. There have been few attempts to draw the experiences of disabled people together within a broad historical context. The multitude of relationships that exist between disabled and able-bodied people is much more complex than simply one of marginalisation. The full range of issues that reflect the history of disability need to be explored, so that the result is a more balanced and historically accurate story. Disabled people are the last understudied minority group. In an attempt to bring together one aspect of that history, which is rooted in a study of rehabilitation, this work will draw out disabled people from the historical shadows.

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[1] For example see Colin Barnes, *Disabled People in Britain and Discrimination* (London, 1991), and Michael Oliver, *Understanding Disability: From Theory to Practice* (London, 1996).

The aim of the thesis is to examine the physical and social welfare of disabled people in Britain between 1918 and 1970. To provide essential background we shall present a short history of the disabled prior to 1939, the primary focus concentrated on social welfare and physical health. A central issue within this study is the period of the Second World War and its impact on the community. The experiences of the war disabled, those injured in industry, and what we have termed the civilian disabled, including children, all contribute to a collective experience of disabled people in the 1939-45 period. It will be argued that the Second World War was of central importance in the evolution of the history of disabled people. Not only did it alter many social, political and economic conventions that had previously been applied to them, but its aftermath altered the face of state provision for disabled people forever.

An important aim of this study is to explain how recreation, exercise and sport were used by disabled people for a variety of purposes, especially those relating to rehabilitation. Such provision was expanded during the war to include a mixture of different disabled people, and the rehabilitative process switched its attention from a concentration on drill and physical health to the active participation of the disabled in sport and games. It will be argued that the use of a scheme of rehabilitation that focused on the physical welfare of disabled people was important for the rebuilding of the disabled patient's confidence in their own abilities, and also with respect to the image of disability within the wider society. The positive use of sport, amongst other things, was important in the post-war

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[2] Jane Campbell and Michael Oliver, *Disability Politics*, (London, 1996), p. 17.

years in bringing about recognition of disabled people within society. It will be shown in this history of disabled people that during the years 1918 to 1970, and beyond, they became transformed from an acquiescent, deferential group to a much more self-confident and assertive one. In the pre-war years, disabled people were largely 'hidden' within society. In the post-war years, as part of their rehabilitation, and as a result of broader social changes and because of their own increased activity, disabled people were able successfully to begin demanding a quality of life, which, while different to that of able-bodied people, gave them a dignity, previously hard to attain.

The remit of this thesis is both broad and complex. There are a wide-range of different types of disability that are explored here, but such a work cannot hope to cover all of the varying types of disabilities that exist. The study concentrates predominantly on those who were amputees, blind, deaf, paralysed or cerebral palsied. One important disease which caused physical disability has been excluded. Tuberculosis has been left out, partly because treatment for TB in general did not feature physical activity as a component. It is also true that there several persuasive studies on this subject.[3] Another key factor in the cause of many disabilities is the onset of old age. Although a wide ranging and fascinating topic, the history of disability among the aged will not be tackled here. While there have been studies of age in Britain, there is scope for further research

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[3] These include Linda Bryder, *Below the Magic Mountain: the Social History of Tuberculosis*, (Oxford, 1988), Thomas Dormandy, *The White Death: A History of Tuberculosis*, (London, 1999), Rowland Parker, *On the Road: the Papworth Story*, (Cambridge, 1977), Pendrill Varrier-Jones, *Papers of a Pioneer*, (London, 1943).

within disability and its relations to ageing.[4] The thesis also does not tell the story of those people who have learning difficulties. There have been historical studies of mental illness, including work on asylums and psychiatric disorders such as shell shock. During the twentieth century, both the medical profession and government agencies began to differentiate between those whose disability was physical and those whose difficulties were judged to be mental.

This study is about physically disabled people. These people were either born with their disability or became so through injury, war or disease. As a result of the two World Wars alone, many tens of thousands became disabled. This group forms an important part of the thesis, as they were numerous and had enough political support so that they could be one of the most successful pressure groups of the early part of the twentieth century. Many medical innovations that had important ramifications for disabled people were developed within the setting of war, which due to their ability to save life increased the numbers of disabled people. One of the most important of these was the development of penicillin in the 1940s. Medical treatment and health issues, although often dismissed by those who study disability politics,[5] is still an important way to learn about disabled people. An understanding of the medical history of disabled people will be considered alongside issues relating to social welfare, charitable assistance

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[4] See Pat Thane, including *Old Age in English History* (Oxford, 2000), and also 'The debate on the declining birth rate in Britain: the menace of an ageing population, 1920s-1950s' in *Continuity and Change,* Vol. 5, No. 2, (1990).

[5] This is what is referred to as the medical model, a belief that the issues of the disabled were treated by doctors as illnesses. For definitions of, and support for the medical model idea see Campbell and Oliver, *Disability Politics,* pp 36-8.

and government policy. There will also be an important focus here on a range of historical testimonies of disabled people. Through this combination of approaches, the thesis will offer a history of disabled people in Britain between, 1918 and 1970, which is grounded within a broad context.

The nature of the various transformations and changes over the period is an important component of the work. Both the shifting nature of disability and disablement itself were influenced by the passing of the years. The thesis therefore highlights the ways in which attitudes towards the nature of different disabilities have changed. What was once considered a serious disability, stomach ulcers for example, is no longer deemed to be so due to the development of health treatments and the refinement of medications to control the condition. Within the contemporary mind, stomach ulcers would not be seen as a disability, yet the most common reason for military discharge in the Second World War was as a result of such an affliction. Equally, children with severe and multiple disabilities are nowadays kept alive when they could not have been before 1945. The expansion of medical knowledge ensure that these children lived, and the development of technologies that are easily used by non-experts and are transportable, mean that many parents can care for their severely disabled children at home. This was simply not possible earlier in the century. To understand the variety of changes that affected disabled people is a reason for the broad time span within this study. It is equally important to understand the role of charity within the disabled world across a longer time frame. It would be

easy to argue that the development of the welfare state ends the need for disabled charities. On the evidence of the 1918 to 1970 period, we shall argue that despite the advent of the welfare state, charity remained, and remains of central importance to the lives of disabled people.

Although all disabled people have experienced changes in health care, social welfare and their public perception, there has been very little investigation into how these have directly affected disabled people. In this thesis we will examine how a variety of economic and social changes have had an impact on the lives of disabled people, and also explore how the unequal treatment of the different disabled groups has been understood both across the disabled community and outside it. We hope to demonstrate that there was no amorphous 'disabled', but a hierarchy of disability that both disabled people and the able-bodied accepted. Disabled people have always lived within an able-bodied world and most perceptions have been externally constructed. This study breaks new ground by attempting to explore disabled history within the context of a fragmented and hierarchical disabled population.

Although the chapters are arranged in a chronological order there are recurrent themes running through them. Chapter One is a broad background that traces the period of the early part of the century to 1939. It sets the scene and develops the theme of the hierarchy of disability, and the progress of the more favoured groups over those less worthy of both sympathy and support. It examines the

slow growth of assistance for disabled people, as well as the early establishment of some of the voluntary societies that remain important today.

Chapter Two covers the same timescale but focuses more sharply on the effects of early methods of treatment on those disabled as a result of the First World War. Although contemporaries did not use the word 'rehabilitation' there were new developments in remedial exercises and physiotherapy that ensured there could be some improvement after injury. The centrality of this therapy in the lives of the war wounded will also be examined. Children's physical education and its effect on their health will also be discussed, as well as important changes to the physical education syllabus that had an impact on disabled children. The difference that the level of support given to certain groups disabled groups over others received was evident in the provision of remedial treatment and also the games they played.

Chapter Three focuses on the Second World War and the medical benefits that saved many lives. The main feature of this chapter is the adoption of rehabilitation methods, and their refinement, by the Forces, and their increasing refinement and sophistication. Probably the most famous treatment regime of rehabilitative therapy was that found in the RAF rehabilitation centres, and a large part of the chapter will deal with their early methods. The effects of this new therapy, for the Forces and the country as a whole is one of the recurring themes of the latter half of this study.

Chapter Four takes a detailed look at the practise of rehabilitation in one particular hospital. From its opening in 1944 the Spinal Unit at the Stoke Mandeville Hospital in Aylesbury was important as, for the first time, rehabilitation treatment was used on a group of disabled people, for whom previously there had been little expectation for survival, the spinal injured. The chapter revolves around the regime at Stoke Mandeville and in particular the efforts of its consultant surgeon, Ludwig Guttmann and his work on rehabilitative practises for this particular disability. It will demonstrate how both the nature of the atmosphere of the Unit and its early patients, who were disabled ex-servicemen, evolved rehabilitation through remedial exercise into organised forms of competitive sport.

It would be virtually impossible to fully grasp the function of rehabilitation in the twentieth century without references to government policy, especially after 1945. Chapter Five explains the reasons behind the adoption of rehabilitation by the State, and the legislation enacted for disabled people for the first time from 1944 to 1960. The rationale for the government's taking up of the rehabilitation service as well as their concentration on employment will be discussed. The NHS, still regarded as one of the greatest achievements of the welfare state, will be considered in relation to both disabled people and rehabilitation. The chapter also examines the dichotomy between the rise of the voluntary services, both in number and influence, alongside the broadening of the welfare state.

Growth and change in activities for disabled people throughout the 1950s is the subject of Chapter Six. Stoke Mandeville's sports days expanded both in scope and the number of competitors to become international. Other recreational activities were developed, often with a therapeutic aim. Indeed the 1950s saw the advance of what was to become one of the most all encompassing pursuits for disabled people, Riding for the Disabled. The chapter concludes with a discussion of the Wolfenden Report to see how far, if at all, the orthodox sporting world had recognised this new and growing area of participation.

Chapter Seven combines two parts, the sporting activities of disabled people and those organising them, are juxtaposed with disabled people's fight for recognition for their welfare and living needs in the 1960s. New administrative bodies that influence disabled sport are a development that is considered. Sport becomes even more organised and includes more disabled groups as the government involves itself in the administration, and to a lesser extent, funding of disabled sport. Voluntary organisations also began to recognise the value of sporting and recreational provision for disabled people as part of their demands for more fulfilling lives.

The final chapter will explain why deaf people are treated separately in this thesis, exploring both their general and recreational history. One of the reasons for marking out deaf people is the subject of rehabilitation. Rehabilitation for deaf people was very different to rehabilitation for all other disabled groups and in that

they are unique. Yet games and sport formed a very important part of many deaf people's recreational time. Their sporting segregation will also form a part of the chapter and the sophisticated nature of their sporting contacts and organisations will be underlined.

The nature and definitions of disabilities have changed over time, as have the perception of disabled people by the able-bodied. Such debates are located in part in a discussion that relates to the terminology of disabled people and the changing nature of the language used to describe them. It is important that this is mentioned, as throughout the thesis words referring to the disabled will be used that many people today would find unpalatable or offensive. However, it is important to use the language contemporaries used as it helps to understand the way disabled people have viewed themselves has changed over time, as well as how able-bodied people thought and felt about them. These terms, which were previously used not only to describe disabilities, and included words like 'crippled', 'spastic' or 'dumb', were also used in the names of voluntary societies, for instance the Central Council for the Care of Cripples, or the Spastic Society. In an article for the *Cripples Journal*, entitled 'The Dreaded Word'; the contemporary concern with terms is unexpectedly humorous.

At the Crippled Children's Week recently instituted by the Wingfield Orthopaedic Hospital, the Mayor appealed to those responsible to drop

> the word 'orthopaedic'. It frightened people away, whereas if 'Cripple' was substituted it would win more public sympathy.[6]

Much of this language has been laid aside in recent years with the 1960s being a decade when a new terminology was born. It was in the sixties that the Central Council for the Care of Cripples was renamed as the Central Council of the Disabled. Even journals with a long history altered their titles in the 1960s, for example, the *National Cripples Journal* which had been published since 1930, became *The Voice of the Disabled* in 1969. Such renaming illustrates the concerns of charities and other organisations towards the convictions of disabled people that they ought to be recognised for exactly that, as people, not as society's poor unfortunates. This is an area that is deserving of closer and further study. Deaf people were often referred to as 'dumb' and by the late 1940s the term 'deaf and dumb' began to be used as a common way to describe those deaf from birth. It was well into the 1950s before the term began to go out of common usage. In 1958, for example, the word 'dumb' was finally removed from title of the Royal School for Deaf Children.

This thesis has relied on a wide range of secondary sources, and these include books and articles about social and medical history, institutional history and works in the field of politics and education. Many of these studies do not have disability as a subject *per se*, in fact some of them do not mentioned disabled people at all, but yet provide information about legislation, services, illnesses and

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[6] 'The Dreaded Word', *The Cripples Journal*, Vol. 1, No. 1, (July 1924), p. 17.

other details that detail an overall picture of life for disabled people at given times in twentieth century Britain. There are notable exceptions to this literary invisibility of disabled people. Roger Cooter's work on orthopaedic surgery discusses rehabilitation in industry and the Armed Forces,[7] and Joanna Bourke's book *Dismembering the Male*, provides insight into masculinity, disability and wounded soldiers.[8] General texts on the welfare state or the war years where disabled people are mentioned are Nicholas Timmins,[9] and Angus Calder[10] respectively.

This is a study of the history of disabled people in the context of rehabilitation achieved through therapies such as physical exercise and sport. Of course, studies of sport are dominated by coverage of the able-bodied, and give scant attention, if any to organised sport or physical exercise for disabled people.[11] One would suggest that this may be partly because those who have studied sport exclude the disabled as they have traditionally concentrated on the activities of elite sports people and have little to say about wider participation. While recruits to the British army of poor physique have always been given drill and exercise, as were their wounded comrades, the physical activities of the armed forces rarely have generally been excluded from sports history. Considering how

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[7] Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organisation of Modern Medicine 1880-1948*, (London, 1993).

[8] Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War*, (London, 1996). For an interesting comparison between soldiers and children see Seth Koven, 'Remembering and Dismembering', *American Historical Review*, no. 99, October 1994, pp 1167-1202.

[9] Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London, 1996).

[10] Angus Calder, *The People's War* (London, 1997).

[11] Both Richard Holt, *Sport and the British*, (Oxford, 1992) and Mason, *Sport in Britain* make no reference to disabled sport. Martin Polley, *Moving the Goalposts: A History of Sport and Society*,

important exercise as physical therapy was to disabled people, and the central place given to rehabilitation during the 1940s and beyond, this is a serious oversight.

The history of disabled people, like that of the disabilities themselves, have been individual histories. Because of this segregation that exists between different groups of the disabled, such as the separation between blind and deaf people, they tend to be studied in isolation, if at all. One of the areas where such segregation has been at its clearest is in the realm of the disabled school. Each school was specific to a particular disability. As a result, disabled children usually feature as part of books on their education, or in the particular history of the schools established for them. In such work, these 'step children of nature' often feature as pupils of great teachers, such as Blanche Nevile, who was a teacher of deaf children.[12] Other books discuss these 'blameless' individuals, who are educated by the State and charitable concerns, such as Chailey Heritage and Oswestry.[13] The livelihood of the children may be explained in relation to the doctors who worked there, particularly in the case of Oswestry, which had the famous orthopaedic surgeon Robert Jones as its consultant.

(London, 1998), remarks on its absence, and Tony Mason and Richard Holt make mention of it in their book *Sport in Britain, 1945-2000* (Oxford, 2000).

[12] Shelia Smith, *Still Unique After All These Years: A History of Blanche Nevile School, Fomerly Tottenham School for the Deaf, 1895-1995* (London, 1995).

[13] See C.W. Kimmins, *Chailey Heritage, 1903-48* (London, 1948) and Robert Jones and Agnes Hunt, *The Heritage of Oswestry 1900-1961* (Oswestry, 1961).

As there is no history, so there is no historiographical debate. This work has been based largely on archival material unused by other scholars. The study of the history of disability is complicated by the diversity and segregated nature of these archives. Those used here relate to specific disabilities such as the Royal National Institute for the Blind or the Royal National Institute for Deaf People. Other records come from specific hospitals and rehabilitation centres such as those at Stoke Mandeville, the Royal Star and Garter Home and Queen Mary's Roehampton Hospital. Central archives, including the Public Record Office, the British Red Cross and the Imperial War Museum have also been used to examine legislation that specifically dealt with disabled people as well as the reports of various government and voluntary committees. Medical journals such as *The Lancet* and the *British Medical Journal* provided an excellent insight into contemporary medical trends and the changing reaction to medical treatment.

In order to capture some sense of the personal experience of disabled people during the period covered by this thesis, often believed to be lacking by those who study public policy, a range of biographies and journals were used. Of key importance here, has been that range of journals written by and for disabled people, including, *The Cord, St Dunstan's Review, National Cripples Journal* and *The British Deaf Times,* all of which offer a unique insight into the lives and concerns of the disabled. Another way of gleaning more personal detail was to use biographies of disabled people. There are many of these and include books

written by those disabled in the Forces,[14] some by famous disabled politicians,[15] and even a few written by people who were neither war heroes nor notable in any way.[16] Many of these books were written in a hospital or institution and reveal much about the nature of disability and how it was treated and coped with in the past. Another essential work was Humphries and Gordon's *Out of Sight: The Experience of Disability 1900-1950*, which accompanied the television documentary of the same name,[17] and which concentrated on the personal experiences of disabled children. No matter how these books are categorised, the reader is given, no matter how imperfectly, some notion of what it was like to be disabled. Books written by medical practitioners who treated disabled people, or about doctors and their work also provide another method of exploring the types of therapies that were used to reduce residual disability.[18]

In summary, the material drawn from archives and the range of journals and these secondary sources, offers a wealth of original material relating to the disabled and their social and physical welfare, much of which has been previously unused.

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[14] Some of these include Paul Brickhill, *Reach for the Sky, The Story of Douglas Bader* (London, 1955), Richard Hillary *The Last Enemy*, (London, 1943), Colin Hodgkinson, *Best Foot Forward*, (London, 1957), and P Huskinson, *Vision Ahead*, (London, 1949).

[15] Examples are Ian Fraser, *Whereas I was Blind*, (London, 1942), and Jack Ashley, *Acts of Defiance*, (London, 1994).

[16] These include Denton Welch, *A Voice Through a Cloud*, (London, 1951), Betsey Barton, *And Now to Live Again*, (New York, 1944), Vera Dean, *Three Steps Forward*, (London, 1957), and Christy Brown, *My Left Foot*, (London, 1954).

[17] At the beginning of the book, Humphries and Gordon write that they had received 1,000 replies to their request for disabled people's experiences, but had chosen the stories that they had felt would be the most interesting to the audience. Steve Humphries and Pamela Gordon, *Out of Sight: the Experience of Disability 1900-1950*, (Plymouth, 1992).

It is clear that the history of disabled people has been overlooked. By examining the diverse nature of the disabled world, the differences that have existed and informed the history of each disabled group can be explained. Key issues and themes, such as the impact of war, the development of the welfare state, changes in medical technology, the nature of charity and the use of sport in rehabilitation are all key areas for studying the changing lives of disabled people. By bringing together the many fragments of evidence which relate to disabled people, the thesis will provide a comprehensive and original study of the physical and social welfare of disabled people in Britain between 1918 and 1970.

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[18] See Susan Goodman, *Spirit of Stoke Mandeville: The Story of Sir Ludwig Guttmann*, (London, 1986), Edward Collis, *The Silver Fleece*, (London, 1936) and Hugh McLeave, *McIndoe: Plastic Surgeon*, (London, 1961).

Chapter 1

'Enormous Losses to Make Up'[1]: Disabled People Before 1939

While alluding generally to the damage that had been created by the First World War, and the size of the task facing Britain, David Lloyd George could have been referring to the challenge that faced the nation's disabled. The First World War had created a new generation of disabled men, whose disabilities ranged from the slight, to those who would, because of complications, die as a result. The impact of the First World War should not however, be overly emphasised. While it created a new disabled group, and led, in part at least, to new approaches towards disabled people in society, the history of disability, and the associated campaigns for recognition, care and livelihood, had a longer standing past.

This chapter will explore the history of disability from the turn of the century to the outbreak of World War Two. Four main groups of disabled people are considered here: children, the war-wounded and the industrial and civilian disabled. One of the main arguments that runs throughout the thesis, and is a central issue in this chapter, was the different treatment, both medical and social, that was afforded each disabled group. It will demonstrate how the state failed to take a uniform approach to disability issues, and favoured the war wounded above all others. This is not to argue, however, that the other groups were completely marginalised. The state developed, in the context of broader welfare reforms, strategies for coping with disabled children and civilians, while a range of

charities and support groups played a key role in their care. Such charities included those associations for both the blind and the deaf that had been established in the latter part of the nineteenth century. The British Foreign Blind Association for Promoting the Education of the Blind had been founded in 1868, and the British Deaf and Dumb Institute was established in Leeds in 1890.[2] There were others that catered for the physically disabled child such as the Invalid Children's Aid Association, which was set up in 1888.[3] Others followed later in the twentieth century, including the Central Council for the Care of Cripples[4], and many other specialist voluntary organisations.

It will be argued here that by understanding the differences that existed between these three groups, it is possible to better appreciate the medical, technological and social changes that affected the lives of the disabled during these years. The First World War, as we shall see acted as a catalyst in changing society's attitude towards the disabled. The steady realisation of the brutality of life on the Western front, was accompanied by the visible signs of the War. Men returned home without sight, hearing and limbs. Many were paralysed permanently; others

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[1]This quote is part of an election speech in Manchester by David Lloyd George on September 12, 1918. Bentley Gilbert, *British Social Policy 1914-1939*, (London, 1970), p. 15.

[2] The British Foreign Blind Association for Promoting the Education of the Blind became the Royal National Institute for the Blind, (RNIB). The National Bureau for Promoting the General Welfare of the Deaf was established in 1911 and eventually became the Royal National Institute for Deaf People. (RNID)

[3] Kate Rackham, *The Invalid Children's Aid Association: The First Ninety Years*, (London, 1977), p. 5.

[4] The Central Council for the Care of Cripples was formed in 1919. See Joan Anderson, *A Record of Fifty Year's Service to the Disabled 1919-1969*, (London, 1969), Frederick Watson, *Civilization and the Cripple*, (London, 1930) and Roger Cooter, *Surgery and Society in Peace and War*, (Basingstoke, 1993), p. 155-157.

scarred. The general spirit of war remembrance, and a sense of society's debt to the sacrifice of its male youth, assisted the war disabled into a privileged place in the eyes of the nation, albeit within the context of the usual standards of care, treatment and support for disabled people. The increased awareness of disability and its associated problems, which emerged from the interest in the war disabled, slowly filtered through to the other disabled groups, and began to transform their circumstances in the years to the Second World War.

A key aspect of this chapter, and an important defining concept for the whole thesis, is the recognition and identification of how attempts were made to restore or 'cure' disabled people. Although dependence on charity and low levels of government intervention were persistent themes of the experience of disabled people.

What then was the setting for the lives of disabled people during this period? The pre-war Liberal government's programme of social legislation had a generally positive effect on the population's health. Housing problems were partially rectified by the Town Planning Act, which was an effort to persuade local authorities to build more dwellings.[5] Attempts to improve children's health was also given priority, and pensions for the elderly were introduced in 1908 and payments began from 1909.[6] There was a renewed interest in the health of the

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[5] Only 11, 000 houses were built between 1909-1915. Gilbert, *British Social Policy*, (1970), p. 138.

[6] The Royal Commission on the Aged Poor submitted its report in 1895. P.H.J.H. Gosden, *Self-Help: Voluntary Associations in the Nineteenth Century*, (London, 1973), p. 280-281.

nation. The disappointing physical condition of recruits during the war and the high levels of injury and disability that was a product of it shaped this debate. Both the State and private charities contributed to the drive toward a healthier Britain. The Ministry of Health was established in 1919, and its increasing responsibilities included caring for the health of the disabled and the welfare of the blind.[7] Later post war legislation tackled housing, public health, food, drugs and workers compensation. An inquiry set up to advise the newly formed Ministry, led to the Dawson Report of 1920, which recommended a state administered medical service which would serve the population as a whole.[8]

A key issue in post-war health reform was the well being of children, and the desire to reduce, as far as possible, the effects of illness and disability from disease. In the post-war years poverty still had a significant affect on the life chances of the newly born to possess or be exposed to diseases or conditions, which could cause disability. Mothers in poor physical condition were more likely to have babies that were weaker than those born to mothers in a better state of health. Diseases like TB and rickets were still relatively common, with the Medical Research Council concluding that 'in most civilised countries, rickets is one of the most common diseases of childhood'.[9] Rickets was caused by a lack of Vitamin D, which softened the developing bones and was characterised by

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[7] W.M. Frazer, *A History of English Public Health 1834-1939*, (London, 1950), p. 350.
[8] Roy Porter, *The Greatest Benefit to Mankind*, (London, 1997), p. 642.
[9] PRO FD 4/20 Medical Research Council, *A Study of Social and Economic Factors in the Causation of Rickets*, 1918, p. 9. In 1919 it was estimated that 80% of children in London schools had rickets. Frazer, *A History of English Public Health*, (1950), p. 407.

bowed legs. In 1918, the Medical Research Council published findings showing that children who had access to fresh air and exercise had less chance of developing rickets.[10]

Tuberculosis continued to pose a serious threat to society's health. It was highly contagious and the pulmonary type had a high level of fatality. The disease could also settle in the bones of the spine, hip and joints, which weakened the affected part of the body thereby reducing mobility.[11] By 1937 the government had introduced legislation to lessen the chances of the public contracting tuberculosis. The Tuberculosis (Attested Herds) Scheme was designed to test every herd in Britain in order to eliminate those cows carrying the disease, but it had little impact by the outbreak of war when TB was still responsible for the majority of deaths within the 15-24 age group.[12] Resistance to mass immunisation with the BCG vaccine meant that TB continued to contribute to large numbers of fatalities and disablement.[13]

Tuberculosis affected people of any age, but there were certain conditions that were more common in children and babies, some of which could have long-term affects including blindness and deafness. In 1910, an epidemic of cerebro-spinal

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[10] PRO FD 4/20 Medical Research Council Report, *A Study of Social and Economic Factors in the Causation of Rickets*, 1918, p. 72.
[11] Thomas Dormandy, *The White Death: A History of Tuberculosis*, (London, 1999), p. 335.
[12] The testing scheme continued, but 1939 were testing only 3% of all herds. PRO FD 4/246 Medical Research Council Report, *Report of the Committee on Tuberculosis in Wartime*, 1942, p. 5.
[13] Anne Hardy, *Health and Medicine in Britain Since 1860*, (London, 2001), p. 101.

meningitis caused many children who contracted it to become deaf.[14] Other more common causes of deafness in children were measles and scarlet fever.[15] Opthalmia neonatorum, which was caused by bacteria carried by the mother and passed to the child during birth, was responsible for large numbers of blind children.[16] The infection that passed the condition to the child was often due to gonorrhoea in the mother.[17] Drops of silver nitrate put in the newborn infant's eyes effectively eliminated Opthalmia Neonatorum. Other more common diseases like measles were more difficult to treat and continued to add to the numbers of disabled children.

As well as the creation of disabled children through the effects of diseases such as TB, gonorrhoea and measles, man made devices added to the ranks. With new technology came added dangers, and increases in the numbers of civilian disabled. As the number of cars on the road grew, children especially had to learn to share their playground space, which was often the street, with these dangerous companions. In 1909 there were 26,091 recorded injuries from cars to pedestrians.[18] Considering that poorer children often did not have access to a safe garden in which to play, they were more often the victims of accident at the hands of the wealthier car owners.[19] As car ownership increased, so did the

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[14] M.G., McLoughlin, *A History of the Education of the Deaf in England*, (Gosport, 1987), p. 193.
[15] PRO FD 4/221 Medical Research Council, *Hearing and Speech in Deaf Children*, 1937. p. 3.
[16] Ian Fraser, *Whereas I was Blind*, (London, 1942), p. 85.
[17] It was estimated that more than half the cases of blindness in children aged 7-16 was caused by venereal disease in the parents. *The Lancet*, (April 4, 1925), p. 717.
[18] Sean O'Connell, *The Car in British Society: Class Gender and Motoring*, (Manchester, 1998), p. 115.
[19] Ibid, p. 119.

number of accidents and more pedestrians were injured. Between 1930 and 1938 there was 182,834 injuries on the road and the majority were pedestrians.[20] The speed limit, which had been abolished in 1930, was re-introduced in 1934 in the Road Traffic Act, and set ten miles higher than previously. In the interests of safety, pedestrian crossings were also introduced, as was the driving test.[21]

With the numbers of disabled children, and the developing charity and welfare cultures of the late nineteenth and early twentieth centuries, attention focused on how these children should be educated. Legislation allowing them to have access to education had begun in the latter part of the nineteenth century.[22] It had advanced slowly for the blind and deaf, but stagnated for the physically and mentally disabled and epileptics.[23] There was great variation in the standards provided for disabled children not only geographically, but also by disability type. In 1893 the Elementary Education (Blind and Deaf) Act was passed and local authorities were supposed to provide and maintain schools for blind and deaf children. The Elementary Education (Defective and Epileptic Children) Act was passed in 1899.[24] This legislation, however, only defined defective children and placed no onus on the local authority to provide them with schooling. The importance of the 1899 Act was that it separated those who had epilepsy from

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[20] For every fatal accident there were thirty non-fatal ones. *The Lancet*, (November 16, 1935), p. 1117.
[21] O'Connell, *The Car in British Society*, (1998), p. 115 & 135.
[22] McLoughlin, *A History of the Education of the Deaf*, (1987), p. 46.
[23] D.G., Pritchard, *Education and the Handicapped 1760-1980*, (London, 1983), p. 195.
[24] Seth Koven, 'Remembering and Dismemberment', *American Historical Review*, (October 1994), p. 1172.

those with mental difficulty.[25] The presumption by the medical establishment that physical disabilities were synonymous with mental ones was only gradually being eroded. Later, during 1915-1917 regulations were added to the Mental Deficiency Act to ensure that deaf children were not certified as also having a learning difficulty.[26]

Medical orthodoxy had long argued that hygiene was important for good health. Such thinking became a key issue in the education and welfare of children. Good health was to be provided by a combination of fresh air, exercise and good nutrition. Medical inspections of children had been established in 1907,[27] and the School Meal Service also provided the nations poor malnourished children with a daily meal. In the case of disabled children, their treatment usually meant 'special' or segregated education, where, it was felt, their needs could be catered for and disabilities reduced or even cured.

One of the most popular forms of this hygienic type of education was the open-air schools. The first of these was established in Charlottenberg, Germany in 1904 and was imitated by the British in 1907.[28] These schools removed children with tuberculosis, rickets, as well as the sickly and malnourished from mainstream education and placed them in what was considered a healthier environment. The

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[25] 'The Evolution of Special Schools', *Special Schools Quarterly*, Vol. 1, No. 2, (March 1911), p. 4.
[26] McLoughlin, *A History of the Education of the Deaf,* (1987), p .47.
[27] Gilbert, *British Social Policy*, (1970), p. 98.
[28] Albert J. Green, 'Open Air Schools for Delicate Children', *The Special Schools Journal*, Vol. XX, No. 2, (June 1930), p. 39.

outdoor regime consisting of open classrooms, afternoon rest and an improved diet and was considered to be highly beneficial for the children.[29] Removal from their unhealthy, crowded environment at home probably did serve to improve their health, yet the regime could be harsh. Children were compelled to sit in blankets in the open-sided classrooms in winter and to endure afternoon naps outside again wrapped in blankets, an unpopular treatment.[30] However those children who stayed within this system for a few years often saw their health improve, mainly due to the better food received there. By 1921 there were fifty-five of these in England and Wales,[31] and the numbers increased throughout the 1930s. There were ninety-five day and fifty-two residential open-air schools with 14,701 students by 1934.[32] As medical knowledge grew as these therapies enjoyed some success, other types began to gather a following. The Sunlight League was established in 1924 by Dr Caleb Saleeby, advocating the benefits of sunshine, opening up the Lansbury Lido in Hyde Park, and other locations where artificial sunlight treatment was given to children and adults.[33] While physically disabled children did attend these schools, others such as those who were blind and deaf required more specialised education. Although some physically disabled children were able to attend mainstream school, blind and deaf children

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[29] Lewis Williams, 'Open-Air Schools', *Special Schools Quarterly*, Vol. 3, No. 2, (June, 1913), p. 34.
[30] Some children complained that during a nap session they had to lie on their right side only – if they lay on their left side or their back they were beaten. Frances Wilmot and Pauline Saul, *A Breath of Fresh Air: Birmingham's Open-Air Schools 1911-1970*, (Chichester, 1998), p. 194.
[31] Five of these schools were residential and fifty were day schools. Board of Education, *Annual Report of the Chief Medical Officer of the Board of Education*, 1921, p.132.
[32] Ralph P Williams, 'Open-Air Schools for Delicate Children', *The Special Schools Journal*, Vol. XXIV, No. 1, (February, 1934), p. 16.
[33] 'Commemoration of Death of Dr Saleeby, *Sunlight*, Vol. 5, No. 1, (Summer, 1943), p. 4.

were often sent to schools that specifically catered for them. There was a higher proportion of residential facilities for the blind and deaf child than for those with other types of disability.[34] The theory behind this segregation was that the average parent did not have the skills necessary to deal with the special needs and training required by a sensory deprived child.[35] As blind children were taught in Braille, teachers were specially trained which was another reason for the need for seperate educational establishments. Segregation started very early. Sunshine Schools for Blind Babies were opened from 1918, and provided a home and teaching facilities for those children aged two to five years who came from poor homes.[36] The Blind Persons Act of 1920 and the Education Act of 1921 both ensured that blind children were schooled from the ages of five to sixteen. Educational services for the blind were the most advanced. Many schools still concentrated on preparing the students for the job market, often concentrating on music, either playing an instrument or tuning pianos, and massage as it was felt that the blind compensated for their lack of sight with heightened senses of sound and touch.[37] Not only were there sixty-seven schools for blind children in 1921, but a public school system had also emerged. Worcester College was a public school for blind boys which opened in 1917. It was soon followed by the establishment of Chorleywood College for Blind Girls in 1921.[38] Whilst education for blind children was more advanced, there were more

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[34] Out of a total of 67 schools for the deaf, 21 were residential and 29 were day. This is in contrast to the physically disabled who out of 75 schools, 60 were day. Board of Education, *Annual Report of the Chief Medical Officer of the Board of Education*, (1921), p. 122.
[35] Ida Mann and Antoinette Pine, *The Science of Seeing*, (London, 1946), p. 199.
[36] RNIB Archives, *National Institute for the Blind Reports 1946-1951*.
[37] Illingworth, *History of the Education of the Blind*, (1910), p. 47 & 53.
[38] *The Lancet*, (July 23, 1921), p. 214.

schools and a prescribed teaching method, children who were deaf were hampered by controversy surrounding teaching methods.

Many children did not however, receive schooling that was specific to their needs. 'Special' schools as they were known, provided teaching for children with a wide range of disabilities. These establishments were funded by both voluntary and government agencies. While in 1900 a child unable to walk would get minimal schooling at home, legislation was later enacted to ensure that disabled children received a minimum standard of teaching.[39] The Education Act of 1918 ensured that local authorities were given responsibility for the teaching of disabled children, but such children continued to depend upon charities. The Invalid Children's Aid Association provided funds and schools for children affected by diseases like tuberculosis as well as those with physical disabilities.[40] In 1921 there were 308 of these institutions, providing day and residential facilities for attendees.[41] Disabled children, unlike their able-bodied counterparts, were compelled by legislation to stay in school until they were sixteen. Whilst at school, they were often provided with medical care, including massage, remedial exercises and instruction in hygiene. Like the blind and deaf, children were accepted into these institutions from a very young age. Chailey in Sussex took

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[39] In 1900 if a child received any education from the authorities it was a twenty minute session twice a week provided by an 'untrained visitor'. Many did not learn how to read or write. Rackam, *Invalid Children's Aid Association*, (1977), p. 27.

[40] TB Homes and open-air schools were opened in 1909, 1913 & 1914 for boys and girls by the ICAA. Rackham, *Invalid Children's Aid Association*, (1977), p.15.

[41] These included children who were blind (67), epileptic (6) , deaf (50), physically disabled (75), tubercular (55), and those in open-air establishments (55). Board of Education, *Annual Report of the Chief Medical Officer of the Board of Education*, (1921), p. 117.

physically disabled children from the age of one month to sixteen years old.[42] The alternative was a place in mainstream education. Some local schools allowed disabled children to attend, but others did not and those with cerebral palsy, for example, were refused admittance on the grounds that they would upset the other children. Some could not go because they were unable to physically get to the school, others because there was little in the way of provision for them when they got there.

The purpose of special schools, while providing a rudimentary education was often to prepare disabled children for different types of low skilled work.[43] One of the best known of these institutions was the Chailey Heritage Craft School, located in Sussex.[44] At Chailey, children were set to work learning a craft, the girls for example being taught weaving, knitting and needlework, and the boys carpentry, and shoe repair.[45] Once they left the school, graduates of these institutions were subject to the vagaries of the job market. There were no government-sponsored sheltered workshops until the establishment of Remploy in 1945.[46] Prospects for the disabled child were dependent, to a large extent, on their social class. The life opportunities of a disabled child were often much better if he or she was born into the middle classes. It has already been mentioned that

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[42] C.W. Kimmins, *Chailey Heritage1903-1948*, (London, 1948), p. 7.
[43] One of the first of these was the Cripples' Home and Industrial School for Girls in 1851. The first one for boys was Wright's Lane Home for Crippled Boys, Kensington. Watson, *Civilization and the Cripple*, (London, 1930), p. 113.
[44] Chailey was formed from a group in London originally established by Grace Kimmins, which was called the League of the Brave Poor Things. See PRO files ED 62 & MOH 102 for further details on Chailey Heritage School.
[45] Kimmins, *Chailey Heritage 1903-1948*, (1948), p. 82.
[46] Edwards, 'Remploy', *International Labour Review*, Vol. 77, (1958), p. 147.

some causes of disability were not restricted by social class, but healthier mothers' generally meant stronger babies. Should disability affect a child the better off family could afford to pay for aids such as a wheelchair that could provide increased mobility. A better diet and health care also ensured that a middle class disabled child was fitter to withstand periods of sickness. Education was not limited to the State system. Private tutors could be hired. As for work, it could be found in an office, and was not always necessary for the middle class child.

For some disabled children, whatever their class, extended periods of hospitalisation were the norm, and as a result, schools were sometimes connected with hospitals. As hospitals and surgeons worked on the ailments of disabled children, provision had to be made for their education. A key example of such an institution was Agnes Hunt's home, in Baschurch, Shropshire, opened specifically for physically disabled children. In 1903, Hunt joined forces with one of the most influential contemporary orthopaedic surgeons, Robert Jones.[47] The *Cripples Journal* was a quarterly magazine published by Hunt and Jones from 1924, which detailed both the work of the hospital and examples of their experiments in orthopaedic surgery. The debates that emanated from the pages of the *Cripples Journal* will be explored later.

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[47] He became the Home's doctor that year and by 1907 the small concern had re-established itself as a hospital. Agnes Hunt, *Reminiscences*, (Shrewsbury, 1935), p. 119 & 123.

Despite the specific problems surrounding the schooling of disabled children, disability was not unusual, and society was used to dealing with the maimed from industry, childhood diseases such as rickets, TB and blindness. But total war nevertheless created a new type of disabled. The First World War opened the public's eyes to the effects of maiming and wounding on a large scale and produced a whole new class of victims. Instead of the poor and unhealthy suffering disability, it was the youngest and fittest men of the country who were monstrously disabled. Thousands were blinded, or deafened, and suffered the loss of limbs, and sometimes sanity.[48] The victims of war had a significant impact on the general public. Disabled ex-servicemen could not be hidden from the public, or segregated in their special schools as disabled children were. After 1918, disabled soldiers were everywhere, on the streets, in the pubs, gnawing away at people's sensibilities.

Conditions at the Front had been horrific. Soldiers who had been injured were prone to infection and gas gangrene. As a result, amputations became common.[49] Without the benefit of modern antibiotics, large flesh wounds took a long time to heal.[50] Even a badly set femur meant that a soldier would have to adjust to life with a limp. Added to this were the affects of delay in treatment

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[48] Although neurasthenia referred to more commonly as shell shock affected large numbers of men during the First World War it is not within the scope of this thesis to cover the mental as well as physical disability. Much has been written on the subject. See Stone, 'Shell-shock and the Psychologists' in Bynum (eds.) *The Anatomy of Madness*, 1985 and the special edition on shell-shock of the *Journal of Contemporary History*, Vol. 35, No. 1, (2000).

[49] There were over 41,000 amputations during the war. Joanna Bourke, *Dismembering the Male*, (London, 1996), p. 33.

[50] In one example, it took 2 years before one soldiers thigh wound had healed enough to be operated on. *British Legion*, Vol. 1, No. 4, (October, 1921), p. 81.

resulting from the slow horse driven ambulances often in use during the early stages of the conflict.[51] The privations of war exacerbated hitherto unknown weaknesses. As it was impossible effectively to screen those with TB at the time some soldiers entered the Forces with it. Such an infectious disease meant that many soldiers contracted it in the army.

While injuries were shocking and severe, advances were being made in medicine and treatment in effort to combat their scale and seriousness. Hospital trains began to be used by 1915 and treatment was carried out in more hygienic surroundings.[52] Using trains also meant that injured soldiers could be moved more quickly to Britain for treatment that was required there. Treatment became more specialised. For orthopaedics the Thomas splint, which prevented many soldiers from the residual effects of badly set bones, was in use by 1915.[53] At his unit in Aldershot, Harold Gillies practised the relatively new treatment of plastic surgery for the disfigured.[54] For those deafened as a result of shell explosions, lip reading classes were instituted. But despite medicine's best efforts and these examples of scientific progress, many servicemen were invalided out of the Forces with permanent disabilities.

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[51] See Frederick Brereton, *The Great War and the R.A.M.C.*, (1919), p. 48.
[52] Douglas, 'Aboard an Ambulance Train 1915-1918', Samuelson, (ed.) *I Owe My Life*, (1995), p. 25.
[53] S. Alan & S. Malkin, 'The Conquest of Disability', *Annals of the Royal College of Surgeons of England*, Vol. 20, (1957), p. 106.
[54] Porter, *The Greatest Benefit to Mankind*, (1997), p. 618.

As more and more maimed discharged soldiers returned home, support services were established primarily to care for and provide welfare services and training for them. Some of these services were well organised and funded, ready to return the disabled ex-serviceman to a life of usefulness and activity.[55] They can be divided into three main types. There was the centre used specifically for training, the hospital and the Home. One of the largest and best known of the first type was St Dunstan's. It opened in 1915 and catered for blind ex-servicemen exclusively. Arthur Pearson, the chairman of St Dunstan's, and his successor Ian Fraser[56] tirelessly promoted their institution and the plight of the blind ex-servicemen. They were taught a wide range of new skills at St Dunstan's including Braille, typing, telephony, poultry keeping, vegetable gardening, and basket making. They lived in the institute or in the area of Regents Park, where it was located, and when the period of training was over they would return home. Assistance provided by St Dunstan's did not end with the conclusion of a training course. Blind ex-servicemen were also given help in finding jobs, financial advice was provided, loans granted and both legal and medical advice was available.[57] An example of a hospital training establishment was Queen Mary's at Roehampton, which opened in the same year as St Dunstan's. Roehampton was the main limb fitting hospital for ex-servicemen in England.[58] Only a small

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[55] In total 1.2 million ex-servicemen were sufficiently disabled to receive a pension, 40,000 of them were seriously disabled. J. M. Winter, *The Great War and the British People*, (London, 1985), p. 273.

[56] Ian Fraser was a blind Conservative member of Parliament from 1924-1929, and 1931-1939. See Fraser, *Whereas I Was Blind*, (1942).

[57] *The Lancet*, (April 6th, 1935), p. 819.

[58] Queen Mary's fitted 26 262 of the 41 050 who lost limbs during the war. Commemorative leaflet, *Queen Mary's (Roehampton) Hospital 1915-1943*.

hospital to begin with, the huge numbers of ex-servicemen with amputations provoked a dramatic increase in the numbers of beds.[59] A soldier who had suffered amputation would be taken to Roehampton where the new limbs would be made, fitted and he was instructed to a level of proficiency in its use.[60] Training in many types of craft, including limb making, were available and there was an employment bureau at Roehampton, but the patient's stay there was only temporary until they were fit enough to return to the family.[61] As well as hospitals, homes were established on a more permanent basis. The Star and Garter Home for Disabled Soldiers and Sailors was created during the war to provide a home for maimed soldiers returning from the battlefields. Administered by the Red Cross, like St Dunstan's and Roehampton, the Star and Garter provided training for disabled ex-servicemen in various activities, but unlike the other two, it was a permanent home for those left disabled by the war.[62]

Other charitable societies were born as a direct result of the war. The Disabled Society was established in 1916 and registered under the War Charities Act.[63] Its main function was to provide information about artificial limbs, arrange for training and disseminate information on caring for the disabled limb; 'a healthy

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[59] Th hospital opened with 25 beds, which rapidly grew to 900 at the end of the war. Ian Fletcher, *Queen Mary's Hospital Roehampton 1915-1965*, (Roehampton, 1965), p. 1.
[60] Workshops for different manufacturers were on site. Roehampton recovered much of its costs from renting out space to limb manufacturers. Helen Alper, (ed.), *A History of Queen Mary's University Hospital Roehampton*, (Roehampton, 1997), p.15-16.
[61] Up to 25 trades and crafts were offered at different times. Alper, *A History of Queen Mary's University Hospital Roehampton*, (1997), p. 15-16.
[62] Weston, 'The Royal Star and Garter Home', Samuelson, *I Owe My Life*, (1995), p. 34.
[63] The Disabled Society experience financial difficulty and was absorbed by the British Legion in 1921. Wootton, *The Official History of the British Legion*, (London, 1956), p. 40.

body and a healthy stump' were considered the most important aspects for a limbless man.[64] The Society also agitated for the provision of a lighter limb, which would be made from aluminium, to replace the heavy wooden ones that were provided at first.[65] Other charities encompassed all disabled ex-servicemen. The Not Forgotten and Lest We Forget Associations, for example, were created in 1920 to ensure that those who had become disabled in the war were not excluded from outings and experiences.[66]

Training was offered to any disabled ex-serviceman who wished to take it up. It was provided by the State at government training centres and by private charities at their own premises like St Dunstan's. The system of curative workshops, which had been established at some crippled children's institutions, provided some training in jobs for the disabled, and became more restricted to ex-servicemen after 1918.[67] The Lord Roberts Memorial Workshops had been established by the Soldiers and Sailors Help Society in 1904[68] and trained disabled ex-servicemen in handicrafts. Although assistance was on offer, many disabled ex-servicemen did not take it up, even though it was clearly in their best interests as, 'The man is not compelled to take training or treatment, but if he refuses to take the treatment recommended, half his pension may be withheld'.[69]

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[64] G. Howson (ed.), *Handbook for the Limbless*, (London, 1922), p. 55.
[65] Howson, *Handbook for the Limbless*, (1922), p. x.
[66] MeGrah, 'Not Forgotten', *The Cord*, Vol. 4, No. 2, (Spring, 1951), p.15.
[67] Watson, *Civilisation and the Cripple*, (1930), p. 30.
[68] Howson, *Handbook for the Limbless*, (1922), p. 108.
[69] Gerrard Harris, *Redemption of the Disabled*, (1919), p. 99.

In 1917 the secretary to the Ministry of Pensions lamented the fact that less than 15% of disabled men were taking up any form of training,[70] despite the fact that the men received an allowance for it as well as travel expenses if the training was over two miles from the their home.[71] The reasons for this lack of interest may be due partly to the fact that unskilled workers wages increased during the two years after the war.[72] During this period, jobs were available, and the disabled wanted to take them up and throw themselves back into the melee of civilian life. During the war the mainly 'private initiative and private financial support'[73] had been augmented by help from the State. Pensions were available for those who had been injured as a result of the war. The government went so far as to establish the Ministry of Pensions in 1916 whose sole function was to provide for the war wounded and by 1918 400,000 ex-servicemen were receiving pensions.[74] These were calculated on a system which judged disability in terms of percentages. For example, the loss of one arm and one eye, two or more limbs, or severe facial disfigurement qualified as 100% disability.[75] A Constant Attendance Allowance was extended to those who required permanent care.[76] Prostheses were provided for ex-servicemen who had lost limbs. Of the 41,050

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[70] Edward T. Devine, *Disabled Soldiers and Sailors*, (New York, 1919), p. 185.
[71] Howson, *Handbook for the Limbless*, (1922), p. 82.
[72] Ross McKibbin, *Classes and Cultures*, (London, 1998), p. 112.
[73] Harris, *Redemption of the Disabled*, (1919), p. 92.
[74] Koven, 'Remembering and Dismemberment', *American Historical Review*, (October 1994), p. 1188.
[75] *The Disabled Soldiers Handbook*, 1918. The lowest percentage was fixed at 20% and was for the loss of two fingers on either hand. Ministry of Pensions Leaflet quoted in Bourke, *Dismembering the Male*, (1996), p. 66.
[76] The Constant Attendance Allowance was mainly provided to double arm amputations. The maximum payment was 20s, which was given to one amputation to the shoulder and the other to the elbow. There were only 50 double arm amputees in Britain. Some blind and double short thigh amputations also received some assistance. Howson, *Handbook for the Limbless*, (1922), p. 147 & xii.

men who had lost one or more limbs due to action in the First World War, all had some type of artificial limb provided. Eligibility for a pension was considered when wounds had disabled a soldier, or his military service had caused a disease such as tuberculosis, or if a previous condition was exacerbated by involvement in the war.[77]

The Local War Pensions Committees were responsible for organising training and medical treatment after the serviceman was discharged.[78] Benefits were extended to an ex-serviceman's wife and children.[79] Other factors also entered into the awarding of a pension, including rank.[80] In comparing the two systems a contemporary American study noted that 'The British policy of complete restoration is rather less democratic than our own, since it recognises social status'.[81] Although the state did assume some responsibility for provision for its war disabled, administration was still based on regional committees. At no stage did the government want to stifle individual enterprise:

> 'It means that a department of governance with a Cabinet Minister is charged with seeing that the state's responsibility is carried out, but that

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[77] *The Disabled Soldiers Handbook*, (1918), p. 7.
[78] Harris, *Redemption of the Disabled*, (1919), p. 98.
[79] Any children born to a disabled soldier after the war were excluded. Koven, 'Remembering and Dismemberment', *American Historical Review*, (October 1994, p. 1191.
[80] It has been argued that for those working or lower middle class men not possessed of a private income, that the promotion to the rank of officer was actually a burden when it came to demobilisation. M. Petter, 'Temporary Gentlemen', *Historical Journal*, no. 37, (1994). See also Antony Brown, *Red for Remembrance*, (London, 1971), p. 8-10.
[81] Harris, *Redemption of the Disabled*, (1919), p. 92. A 100% pension in 1919 was from 27s 6d for a private and 42s 6d for a Warrant Officer Class 1. Devine, *Disabled Soldiers and Sailors*, (1919), p. 168.

this department is expected to fulfil its function largely by stimulating local and private effort'.[82]

Disability pensions were surrounded by controversy. Differing amounts were awarded to ex-servicemen who had served in other conflicts.[83] Despite the establishment of the Ministry of Pensions, the government did not want the long-term costs of the war to be too heavy on its purse. Those ex-servicemen who had been turned down by the Local Committees, known to be dubious about the effect of an ex-servicemen's disablement on their earning capacity, had recourse to the Appeals Tribunals who often shared the views of the Committees.[84] Gaining a pension was not always an easy prospect.

As we have seen, the war wounded were offered training which would ostensibly provide them with new jobs to fit their altered bodies. They were also occasionally given preference for some jobs. This was evident in schemes such as the Kings National Roll, which protected the employment of the war disabled and ensured that it was financially beneficial for companies to take them on. The Roll was established in 1919, by Royal Proclamation. Companies had to fulfil specific criteria before they were allowed to use the special identifying seal, which included drawing 5% of the workforce from the war disabled who were

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[82] Devine, *Disabled Soldiers and Sailors*, (1919), p. 183.
[83] Rules for the awarding of pensions were very complex. For example, a soldier from a previous war would only receive a World War One disability pension if he had fourteen years service previous to his disablement and served again during the war, but he did not have to be disabled in the fighting to get the World War One pension rate. *British Legion*, Vol. 1, No. 1, (July, 1921), p. 17.
[84] *British Legion*, Vol. 1, No. 11, (May, 1922), p. 247.

drawing pensions.[85] It was beneficial to the companies to be included on the Roll because preference was shown towards them for government contracts.[86] The problem for disabled ex-servicemen was that a 20% disability was given equal weight with a 100% rating, so that employers tended to take on the less disabled and were still able to fulfil the criteria.[87] Yet the scheme rapidly lost favour with employers, so that by 1922, only 39% of firms wished to renew their membership.[88] The employment situation for the more severely disabled continued to be problematic. Ex-servicemen's associations tried to find jobs for them. In 1921, the Disabled Society, which had amalgamated with the British Legion, had asked the Legion to provide funds to establish a Poppy Factory. The Legion provided £2,000 and from then on severely disabled men found employment making poppies.[89]

The British Legion became a staunch ally of disabled ex-servicemen.[90] Although there was a diverse range of groups who purported to represent and support them, it was not until the British Legion was formed in 1921 that the war wounded

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[85] This excluded members of the Merchant Navy and Civil Defence.
[86] PRO CAB 117/145 Tomlinson, *Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, January 1943, p. 22. See also CMA SA/RBC C 8.9 Tomlinson's address to the Association of the Royal Empire Society, 'Rehabilitation in Industry of Disabled Servicemen', March 23, 1944.
[87] By February 1920 10,867 employers were using the seal and employing 102,011 disabled ex-servicemen. Howson, *Handbook for the Limbless*, (1922), p. 69.
[88] *British Legion*, Vol. 2, No. 1, (July, 1922), p. 14.
[89] Account in Brown, *Red for Remembrance*, (1971), pp. 80-85.
[90] The British Legion represented the interests of all ex-servicemen who joined. They had a Women's Section comprised mainly of war widows. In 1922 membership stood at 122,986 and reached its highest level of pre World War Two membership of 526,413 in 1939. Wootton, *History of the British Legion*, (1956), p. 305.

found a more influential voice.[91] After the war, groups like the Legion tried to ensure that those disabled in the war in particular would have opportunities that were available to all citizens.[92] It also agitated for preferential treatment for employment for disabled ex-servicemen and sought to abolish the Ministry of Pensions rule that a claim for a pension for a war-related disability must be made within seven years of the war's end. At first, the Legion funded itself mainly from subscriptions and appeals.[93] Later it financed itself further with the profits from the British Legion Disabled Men's Industries as well as receipts from Poppy Day.[94] The Legion also set up an industrial colony and sanatorium for those ex-servicemen suffering from TB. Preston Hall, in Kent became a large and famous tuberculosis treatment centre.[95]

Although it can be argued that the war disabled had little bestowed on them in the way of large scale centralised assistance and benefits, they were better provided for than other disabled groups of the same period. The State had assumed a larger responsibility for the disabled ex-servicemen of the First World War then for any previous conflict. An entire Ministry had been established, aids such as prostheses were provided free of charge, and training was available.

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[91] The Blackburn(later National) Association (1916), the National Federation (1917), the Comrades of the Great War (1917) and the Disabled Society (1916) amalgamated in 1921 to form the British Legion. Graham Wootton, *The Politics of Influence*, (London, 1963), p. 63.
[92] Heaf, The British Legion and Rehabilitation', *Rehabilitation*, No. 54, (July-September 1965), p. 53.
[93] The first appeal was Warriors Day, which was held in March 1921 but this was replaced by Poppy Day in November of that same year. Wootton, *The Official History of the British Legion*, (1956), p. 38.
[94] Wootton, *The Official History of the British Legion*, (1956), p. 38.
[95] Heaf, The British Legion and Rehabilitation', *Rehabilitation*, No. 54, (July-September 1965), p. 53.

When the State system failed them, the war wounded had a large organised association like the British Legion to represent them. When there were complaints levelled at the Appeals Tribunals, which handled pension disputes, the British Legion announced that they would be carefully watching the tribunal's activities to ensure that their members were treated fairly.[96] Disabled ex-servicemen did receive a pension whereas civilian disabled did not. In comparison to wounded nurses, for example, disabled ex-servicemen were well provided for. A disabled nurse was only given a promise that any claims made by her would be 'considered'. Nurses could apply for a pension or a gratuity in lieu as well as asking for payments for re-training.[97] A woman who had served in the war did not presume to merit the awards given to a man who had been injured while fighting for his country.

> Whenever, therefore, a country is considering the making of provision for the handicapped and their rehabilitation, the veterans come first...In even very advanced countries it is possible for the State's resources to provide only for the veteran and for the handicapped child and adults disabled in civil life to be left to the more or less generous mercy of private or semi-private charity.[98]

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[96] *British Legion*, Vol. 1, No. 11, (May 1922), p. 247.
[97] Howson, *Handbook for the Limbless*, (1922), p. 156.
[98] John D. Kershaw, *Handicapped Children*, (London, 1961), p. 13.

There was no doubt of the preferential position afforded to disabled ex-servicemen. When the patients at Roehampton went on strike because their weekend leave was stopped, the Minister of Pensions warned the recalcitrant patients to obey the rules. He added, 'I may point out that the facilities granted are considerably in excess of those allowed by civil hospitals'.[99]

Even after the war had been over for six years, ex-servicemen continued to be provided with better facilities and a number of institutions to help them. Still more disabled ex-service organisations were created in the 1930s. The British Ex-Servicemen's Limbless Association was set up in 1932 and worked to promote issues such as the improvement of artificial limbs for those who had lost them in the War.[100]

War and work were the two areas responsible for the production of the most disability. As we have seen, those disabled by war were provided with pensions and benefits and had a significant amount of charitable support. The same could not be said for the industrial worker. As Bentley Gilbert states, 'The nation gave a pension to a soldier but not to a man who served his country by a life of honest industry'.[101]

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[99] Weekend leave at Roehampton was cancelled because the patients took it whether or not it had been granted. *The Lancet*, (May 16, 1925), p. 1058.
[100] For further detail, see The British Limbless Ex-Servicemen's Association's official history. Peter Ryde, *Out on a Limb: A Celebration of the British Limbless Ex-servicemen's Association Golden Jubilee 1932-1982*, (London, 1982).
[101] Gilbert, *The Evolution of National Insurance in Great Britain*, (1966), p. 71.

Conditions in factories and other heavy industry were the location of many accidents which often led to permanent disablement. Although there had been significant improvements in factories since the nineteenth century, there was still little safety provision and no equipment to protect the workers from hazards such as chemical spills or loud noise. The National Insurance Act of 1911 was a very important piece of legislation, as it enabled workers, for the first time, to insure themselves against unemployment, caused by accident. [102] Although the State provided the means with which the population could insure themselves, the government did not provide the insurance, but relied on a group of 'approved or friendly societies to assist the insured with benefits'.[103] According to the statutes, the law decreed that an injured worker should be paid thirty shillings a week but there was no notion of where this money would come from should the company go broke and the government did not provide any capital for such benefits.[104] These included health care and visits to the doctor, but this was for the insured worker only. Other anomalies existed within the system. If a worker required substantial aids such as crutches or an artificial limb, these were considered 'additional benefits', to which the person was not always entitled. They might have to apply to charities such as the Royal Surgical Aid Society.[105] Whilst national insurance benefit paid for recovery while the worker was ill or recovering from accident, it did not provide for long term disablement. For those whose

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[102] The benefits did not start until January 1913. Gilbert, *British Social Policy,* (1970), p. 103.
[103] Gosdon, *Self-Help*, (1973), p. 282.
[104] Smyth, J.L., 'Industrial Accidents and rehabilitation' in Invalid Children's Aid Association/ Central Council for Care of Cripples, *The Welfare of Cripples and Invalid Children*, (1935), p. 91.
[105] The charitable organisation, the Royal Surgical Aid Society provided items such as spectacles and artificial limbs to those unable to afford them. Ursula Keeble, *Aids and Adaptations*, (London, 1979), p. 23.

sickness extended beyond the regulation twenty-six weeks, benefits were reduced by half.[106] The practise of persuading the injured worker to sign away their right to compensation for a cash payout still continued. Workers did not have much bargaining strength if they suffered disabling injury; compensation was very small, and since the victim was often the main household earner injury at work could plunge the household headlong into poverty.

The exception to the somewhat insufficient provision for the seriously and permanently injured in the workplace was the mining industry. Mining was one of the most dangerous occupations and safety had long been an important issue. In 1911, the Coal Mines Act contained rules to protect miners from some of the specific injuries and conditions that were associated with those employed in the industry.[107] As well as the obvious dangers of working underground[108], there was the added risk of pneumoconiosis, a lung condition caused by inhalation of dust and a variety of other conditions, such as beat hand, knee or elbow, where the skin became swollen and infected from the constant use of equipment used to dig out coal.[109] Serious cases sometimes required amputation. In 1924 the Medical Research Council examined mining at the 'insistence' of the Mines Department, who wished to reduce the many compensation causes associated with the industry.

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[106] Charles Webster, 'Health, Welfare and Unemployment', *Past and Present*, 109, (1985), p. 211.
[107] Donald Hunter, *The Diseases of Occupations*, (London, 1978), p. 223.
[108] 90% of cases of paraplegia can be attributed to accidents in mines during peacetime. Hunter, *Diseases of Occupations*, (1978), p. 1116.
[109] PRO FD 4/98 Medical Research Council, *Report on Miners 'Beat Knee', 'Beat Hand' and 'Beat Elbow'*, 1924. PRO FD 4/243, Medical Research Council, 'Chronic Pulmonary disease in South Wales Coalminers', 1924.

> ...Although general mortality is low, (miners) suffers more from occupational diseases which are subject to compensation than any other industry in the country.[110]

Not only was the health of miners of concern. In 1920 the Mining Industry Act had supplied funding from a levy on the price of coal in order to provide additional facilities for the recreation and education of miners. In 1926, further legislation was enacted to ensure that pithead baths were installed so the workers could wash before they went home.[111] There were also special hospitals and medical services for miners like Berry Hill near Mansfield, but these were largely a result of trade union activity.[112] While the State did not provide miners with the scope of benefits given to the war wounded, mining was an important enough industry to warrant special treatment and concessions.

Whether a workman was well compensated or not, resources were not being put into a system of rehabilitating those injured in industry.[113] By the middle of the 1930s steps were beginning to be taken to provide some workers facilities for rehabilitation. In 1935 the Delevingne Committee was set up to report on the rehabilitation of workers industrial injuries, and more usefully, training centres

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[110] PRO FD 4/98 Medical Research Council Report, *Report on Miners 'Beat Knee', 'Beat Hand' and 'Beat Elbow'*, 1924.
[111] Hunter, *Diseases of Occupations*, (1978), p. 226. See also Barry Supple, *A History of the British Coal Industry*, Vol. 4, (Oxford, 1987).
[112] Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organisation of Modern Medicine 1880-1948*, (Hampshire, 1993), p. 207.
[113] *The Lancet*, (April 6, 1935), p. 817.

opened where disabled workers could learn new skills. It submitted its final report in 1939, and made recommendations regarding the plight of the injured worker. The report concentrated principally on fractures and the establishment of an organised fracture service. It also emphasised that remedial training for those who had sustained fractures remained inadequate, and underlined that this could be a cause of residual disability.[114] It suggested that services supplied to ex-servicemen be expanded to cover workers who had been injured. It referred specifically to artificial limbs and the need to use the expertise of the limb fitters at Roehampton to benefit the industrial disabled. The system of curative workshops in hospitals and fracture clinics to aid in minimising later disablement ought to be available in all hospitals throughout the country. However, the Committee did not suggest that the government fund the service, but rather that money should be made available under the Poor Law if a patient qualified for assistance.[115] There were investigations of the affects of different types of work, such as the Committee on Industrial Pulmonary Disease. There were queries about the death rates and the costs of compensation that was said to be £100,000 in one year.[116] Recommendations were often made,[117] but there was no legislation that forced companies to provide adequate standards of safety and

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[114] *British Medical Journal*, (August 19, 1939), p. 418.
[115] Ministry of Health, *Final Report of the Inter-departmental Committee on the Rehabilitation of Persons Injured by Accidents* (Delevigne Committee) 1939.
[116] PRO FD 4/199 Medical Research Council Report, *Physical Methods for the Estimation of Dust Hazard in Industry*, 1935. The year in question is not detailed, but the Committee on Industrial Pulmonary Disease was established in 1930, so presumably this cost occurred between 1930-1934.
[117] PRO FD 4/199 Medical Research Council Report, *Physical Methods for the Estimation of Dust Hazard in Industry*, 1935. Lomax and Whytlaw-Gray recommended that stone masons should not work in enclosed spaces , respirators should be used and dust should be swept off stones regularly.

welfare for their workers.[118] The Workman's Compensation Act of 1937 did make health and safety more of a priority.[119] Gradually the expertise that had been provided to the disabled ex-serviceman was becoming available to a select group of civilians. In 1936, for example, some disabled people were provided with artificial limbs from Roehampton. These were industrial cases, primarily men employed in railways and mining, although there were a few non-industrial cases accepted.[120] Although this provision was made, often the service was not as high a standard as the war wounded received, in regard to training and support. As Ron Moore, a young civilian amputee stated,

> Roehampton delivered one pair of legs to me; there was no advice, no help, just the usual 'good luck mate'. ...The artificial legs rubbed blisters where they joined the tops of my legs and they often bled.[121]

The complicated fitting process and prolonged period at Roehampton for training in the limb's use, provided for disabled ex-servicemen, was not offered to him.

So far, this chapter has concentrated mainly on the story of disabled ex-servicemen and children, and to a lesser extent, the disabled industrial worker. This mirrors the preoccupation of both the public and private authorities that

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[118] Helen Jones, *Health and Society in Twentieth Century Britain*, (London, 1994), p. 71.
[119] See Peter Bartrip, 'The Rise and Decline of Workman's Compensation', in Paul Weindling, *The Social History of Occupational Health*, (London, 1985), pp. 157-179.
[120] From October 1936 – 1943 there were 3,151 civilian cases dealt with as well as an unspecified number of private cases. Commemorative leaflet *Queen Mary's (Roehampton) Hospital 1915-1943.*
[121] Steve Humphries and Pamela Gordon, *Out of Sight*, (Plymouth, 1992), p. 124.

concentrated on the plight of these two groups. As we have seen, although charities provided a lifeline to some disabled people, they tended to focus on particular groups of disabled people, such as the war wounded. Children with disabilities were also seen as a group deserving of charity, and there was a social responsibility to see them provided with an education. But disabled adults found help more difficult to obtain with both private enterprise reluctant to shoulder responsibility. Nor did they have representation from their own organisations, nor the benefit of the emotive notion of sacrifice, which surrounded the war disabled. The bottom rung on the ladder of disability prior to the Second World War were those that can be dubbed the adult 'civilian' disabled. Aids such as wheelchairs or prostheses were often beyond their means. For those not of school age, and often without the advantage of education, they presented a 'considerable economic problem.'[122] The Central Council for the Care of Cripples, which was established in 1919 only began to tackle the issue of disabled adults in 1925.[123] In 1927 when the Voluntary Orthopaedic County Associations surveyed the number of cripples in England by visiting homes around the country[124], they found many disabled adults living in family homes, hidden from the outside world.

> Immediately the houses of the poor in slums and country cottages revealed pitiful secrets of grown or partially grown men and women,

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[122] Watson, *Civilisation and the Cripple*, (1930), p. 34.
[123] Anderson, *A Record of Fifty Years Service*, (1969), p.13.
[124] Robert Jones & Agnes Hunt, *The Heritage of Oswestry*, (Oswestry, 1961), p. 70.

> usually quite unlettered, quite useless, quite hopeless and often incurable.[125]

Later, efforts to highlight the experience of physically disabled civilians was made by private individuals. One of these enterprises was the publication of *the National Cripples Journal* in 1930.[126] The purpose of the journal written by disabled people themselves, and sold door to door, was to bring the plight of physically disabled people to the public's attention. Their objective was stated on the front page of each issue,

> We want to get national recognition for crippled people in the same way it is given to the blind, our comrades in distress. We do not want to be dependent on charity, but want National Workshops with a living wage for partially disabled cripples, and for the poor cripple in the spinal carriage we want a small weekly pension instead of Poor Relief. It is dreadful to be totally disabled and also in distress.[127]

The *National Cripples Journal* was particularly concerned with issues affecting disabled individuals.[128] Other journals existed, usually with a view of promoting their own particular viewpoint, as in *Sunlight*, the publication of the Sunlight

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[125] Watson, *Civilisation and the Cripple*, (1930), p. 36.
[126] It was renamed *The Voice of the Disabled* in 1969, and was published until 1980.
[127] *National Cripples Journal*, No. 7, (January 1931), p. 1.
[128] One of their campaigns was to persuade the railway companies to cease charging a disabled person more than double the normal fare when they travelled with their invalid chair. *National Cripples Journal*, No. 17, (1933), p. 6.

League, or *The Cripples Journal*, which was produced by Robert Jones and Agnes Hunt, founder of the Oswestry School.

The civilian disabled, while lacking in charitable support, also had real problems in securing employment. At a conference in 1921 it was noted,

> Every cripple must eventually compete in the labour market with healthy rivals and unless he has been educated and taught a trade his position is hopeless.[129]

In an effort to tackle such problems, institutions for training disabled people for work were eventually set up by the Ministry of Labour, after some pressure from associations such as the Central Council for the Care of Cripples. The Queen Elizabeth Training College for the Disabled was established at Leatherhead in 1935.[130] Others soon followed, two years later St Loyes College for the Training and Rehabilitation of the Disabled opened.[131] The 1930s saw a burgeoning of curative workshops and residential factories, like Cripplecraft where local authorities would fund places for disabled people to be trained for work.[132] Some workshops were closely associated with a hospital. The Stanmore Enterprise, for example, was linked with the work of the Royal National Orthopaedic Hospital. In

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[129] *The Lancet*, (August 6, 1921), p. 305.
[130] Anderson, *A Record of Fifty Years Service*, (1969), p. 15.
[131] Lord Beveridge, *Voluntary Action: A Report of the Methods of Social Advance*, (London, 1948), p. 244.
[132] Cripplecraft was a workshop in Sevenoaks where disabled people made toys. Joan Simeon Clarke, *Disabled Citizens*, (London, 1951), p. 176-177.

1937, the Enterprise opened to accept young crippled men, paid for by their local authority, who were trained in trades including boot-making, upholstery, sign-writing, tailoring and watch-repair.[133] Others such as the Surrey Voluntary Association for Cripples came into being in 1935, but this was a private charity, and not provided with any central funding. These workshops, whether paid for by donation, or provided with State grants were important, as many of them released a new source of labour, which was important as Britain began to prepare for war in the latter stage of the 1930s.

One of the most important issues for all groups of disabled people was their survival in an able-bodied world, a world for some that was essentially alien and difficult. How were disabled people able to achieve recognition from the able-bodied? The main route to public acceptance was through employment. Not only was work rewarding in a monetary sense, it gave disabled people a form of equality and removed the stigma of being a burden on society. It was important for the public to see that disabled people could be useful members of society and not be simply reliant on help from outside, whether government or privately sponsored. Although work was important, the types of jobs open to disabled people were somewhat limited.

One way in which the Central Committee for the Care of Cripples worked to achieve recognition for the civilian disabled was by promoting products made by them. It organised four International Exhibitions of 'Cripples Work' in Exeter in

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[133] *The British Medical Journal*, (July 17, 1937), p. 129.

1929, Nottingham in 1931, Bristol in 1934 and Edinburgh in 1937. In doing so, the Committee demonstrated the abilities of those who were disabled.[134] Other local disabled groups such as the Leicester Guild of Cripples, made artificial flowers both in order to support itself as well as to demonstrate that disabled people could do a days work.[135]

Since disabled people often received little support then it might be presumed that disabled people were a quiescent group. In many cases this was true. Public demonstration was not the province of many disabled people, but there were some for whom it proved an effective method of gaining further concessions. The blind were the most public and politically active disabled group during the immediate post-war period.[136] In April 1920, for example, a group of 250 blind men marched to London from all over the country to insist that the government 'accept responsibility for the direct maintenance of the Blind from Public Funds.'[137] They did not have long to wait as the action resulted in the Blind Persons Act of 1920. The very favourable conditions that the blind were given in the Act were in stark contrast to the lot of other disabled groups at the time.[138] One of the reasons why this action was so successful was that blindness was the

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[134] The fifth exhibition, scheduled for 1939, was cancelled due to the outbreak of war. Anderson, *A Record of Fifty Years Service*, (1969), p. 26.
[135] Derek Seaton, *From Strength to Strength*, (Leicester, 1998), p. 46.
[136] Even previously, the blind have organised in a way that other disabled groups did not. In 1899 workshops for blind people were registered as independent trade unions, in 1902 they affiliated with the TUC and in 1909 the Labour Party. Campbell & Oliver, *Disability Politics*, (1996), p. 47.
[137] PRO MH 55/590 Letter from the General Secretary of the National League of the Blind of Great Britain and Ireland, to all sub-sections of the League, (no date presumably 1936).
[138] These included old Age Pensions provided for the blind at age 50, and the local authority was given responsibility to provide for blind welfare. Southern Regional Association for the Blind, *Chronological Summary*, (London, 1965), p. 6.

most acceptable and recognisable of the disabilities throughout the early part of the century, with many of the general public feeling most sympathetic to those without sight.[139] The march was repeated in 1936, with similar aims to that of 1920, and many men from blind workshops in the north of the country marched on London, this time with less effect.

The 'favoured' status of the blind demonstrated that there was a clear hierarchy of disabled groups. Charity and state favoured some groups whilst others were marginalised and forgotten. It was felt by some associations like the Council for the Care of Cripples that there was too much emphasis on the victims of the war, and that the civilian disabled were not getting the type of treatment to which they were entitled. But there was little suggestion that the Government would do much about this in the years before 1939.

> ...It is most desirable that so far as possible our social services are not under official jurisdiction. Their removal from the political arena has given them a direct touch with the working classes, which is of the highest possible importance. It holds the door open to co-operation in a sense that State-paid; State-aided control can never perform except at a further enormous increase on national debt and bureaucracy.[140]

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[139] As a comparison, here are two quotes from the same source. 'Blindness is a handicap so severe that it has long gripped the sympathy of civilised peoples.' Contrast the previous statement with, 'Deaf intelligent children can grow into an adult with attributes so nearly normal that he can take his place amongst ordinary citizens.' Clarke, *Disabled Citizens*, (1951), p. 24 & p. 99.

[140] Watson, *Civilisation and the Cripple*, (1930), p. 107.

The civilian disabled directly would have to wait for the establishment of the welfare state.

Aids for disabled people were generally at a low level of technological development. Although in the case of the blind and deaf, steps had been taken to aid their communication, with the Braille system and the manual alphabet, physical aids to assist disabilities were not routinely available. As we have seen, provision of an artificial limb, for example, was dependent on how a person had become disabled, and an ex-serviceman with his war wounds was a more worthy disabled person than a civilian with a birth defect. Charities who provided limbs and other surgical appliances had a number of standard items, which in consequence often did not fit, as the wearers had not been specially measured for the prosthesis. Deafness was a particular problem. Doctors were not able to judge whether or not it could be helped by hearing aids. One result was that many deaf people purchased hearing aids that were useless to them.[141] Early hearing aids were often cumbersome and to use them, the deaf person had to sit with the apparatus because it was not transportable. There was no help from Government with payment for these items and as many had to be imported from America, they were expensive. Not until the National Health Service was established after the war was there any assistance with hearing aids for the deaf. Blind people were in a similar situation with regard to the poor standard of

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[141] Deaf people were warned to ensure that they were buying their aids from a reputable dealer as dishonest suppliers had duped many.

physical aids. Many blind people relied on the sighted to get around. For those who went out on their own, they had to rely on the assistance of able-bodied people to act as their eyes and assist them with more hazardous activities, like crossing a road. The white cane that is closely associated with the blind was a much later development.[142] That other symbol, the guide dog, was not widely in use before 1939. The reason for the rejection of the emblem that became synonymous with blindness later in the century was the social stigma of a blind person and a dog. Often a blind person walking with a dog signified that he was a beggar. The dog would lead him to his pitch, help to attract attention, and therefore add to the takings.[143]

Disability prior to the outbreak of the Second World War was a complicated conglomeration of different conditions and afflictions. As this chapter has shown, it took many forms and was a product of birth, disease, accident, poverty, work and war. The First World War increased the public profile of disablement as the bodies of many young, strong men returned to Britain severely damaged. The country faced up to the problem of these broken bodies with the provision of pensions for them. Whilst not always adequate, the worthy disabled from the war were still better provided for than those who were disabled following an accident or a birth defect.

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[142] The white cane was introduced in the 1930s as part of the 'Safety First' campaign, and the long cane used in the 1960s. June Rose, *Changing Focus: the Development of Blind Welfare in Britain*, (London, 1970), p. 97.
[143] Fraser, *Whereas I was Blind*, (1942), p. 14.

It is almost universally accepted that they have 'given' their sight, their hearing or their limbs to save their fellow countrymen from nameless horrors, and whether they were volunteers or conscripts, brave men or cowards the sacrifice sanctifies them.[144]

War heroes were cared for by the State and many charities but government aid on the same scale did not extend so far to disabled children, nor those injured in industry, nor the adult civilian disabled.

The State did not ignore the disabled completely. Indeed its awareness of disabled people grew, and with it the development of material aid, if at varying and low rates. The Government was only active fiscally in the lives of the disabled victims of war, preferring to support them and to leave disabled civilians to the care of the voluntary services. Children were slightly better off as they were provided with an education, of varying quality, and were more likely be supported by charity due to their more helpless role in society because of their youth and perceived vulnerability. During the 1930s, the Factory Acts and medical committees began concerning themselves with workers health and the prevention of accidents. The least deserving disabled were civilian, too old for schooling. Adults were expected to be independent and fend for themselves. Charity or the Poor Law were the only resort for most ordinary disabled people and doubtless it was better than no help at all. Both aid societies and treatment centres such as fracture clinics expanded throughout this period, particularly in

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[144] Kershaw, *Handicapped Children*, 1961.p.13.

the latter stages of the 1930s. Before the outbreak of the Second World War, a key feature of restoring disabled people, the use of sport and physical exercise emerged, and this development will be discussed in chapter two.

PAGE
NUMBERS
CUT OFF
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ORIGINAL

Chapter 2

The C3[1] Society: *Disability, Health and Physical Exercise before 1939*

> Much of our population is stigmatised as C3, and, so closely do the two co-operate, that this reproach applies not only to our bodies, but also to our uninspired minds.[2]

There existed a wide spread perception in the years immediately after the First World War that the general health of the British population was low. Despite a plethora of conferences on physical deterioration, and concern about nutrition, especially amongst children, in the pre-1914 period, there was little that was done in the way of practical assistance. In light of the health of the nation debate, and as a result of the early steps that were taken in creating a welfare system, the situation began to slowly change, and throughout the inter-war years there were various initiatives to try and improve the situation.

This chapter will explore the history of disability, health and physical exercise in the period to the outbreak of the Second World War. The thesis will demonstrate later how important the post-Second World War developments, especially at the Stoke Mandeville Hospital were, but was the 1900-39 period one where the disabled were inactive? By focusing on the three major groups identified in the previous chapter – children, war wounded and the civilian and industrially disabled, it will be possible to examine how sport and physical exercise became a part of the lives of disabled people. The chapter will examine how such use of sport and physical exercise was sometimes part of

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[1] This letter/number combination refers to fitness grades that were given would be recruits when they went into the Forces. A1 was the highest rating.

a medical programme of rehabilitation, while at others it was the product of the need for disabled people to amuse and socialise themselves.

It is clear that medical orthodoxy in the inter-war years believed that the provision of exercise was considered to be good for both the physical and mental constitution. There were however a few disabilities that exercise as therapy did not touch, and these will be highlighted. For all disabled groups, their condition, as well as any latent poor character would, it was believed by many, be righted by application to physical exercise. Although in some cases sport was played as part of the routine of drill and movement, its practise, as will be demonstrated, developed differently for the varied groups of disabled people. For some its practise as therapy was negligible, and for others, sport was firmly rooted in a disabled group's organisation. As the deaf had established their own International Silent Games by 1924, their unique narrative will be the topic for chapter eight. In its entirety this chapter argues that sport and physical exercise had become a feature of the lives of disabled people by 1939. Amongst among medical practitioners, its benefits as part of rehabilitation, especially with regard physical drill but not sport generally, had been recognised.

One of the key steps in recognising the importance of exercise for the health of the nation was the 1920 the Dawson interim Report on the future of medical provision.[3] The report recommended that physical exercise and games be

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[2] Prunella Stack, 'National Fitness', in Mayers et al, *Where Do We Go From Here?*, (London, 1938), p. 129.
[3] David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century*, (Cambridge, 1983), p. 32.

one of the main focuses in maintaining a healthy body.[4] In a similar vein, and adding to the weight of evidence that exercise was good for the population, were experiments conducted on puppies in 1921. These demonstrated that lack of exercise was a contributing factor in the development of rickets in the laboratory animals.[5] Although this exercise theory was later given less credence in 1922, and the theoretical preference was given to the lack of Vitamin D, it still figured as a marker of the need to get Britain fit.[6] In the 1930s the emphasis on physical fitness as a key component of health continued. The Central Council of Physical Recreation which was established in 1935 and its function was to co-ordinate sporting associations that did not already have their own official support.[7] This fitness trend spread from schools to the factories for the able-bodied. The keep fit campaign of the 1930s supported by the Central Council of Physical Recreation in 1935, was also designed to keep women and girls who worked in factories up to a reasonable standard of fitness.[8] This was not necessarily designed for disabled people, but it did make for stronger women having more healthy babies, which was a type of preventative medicine. Wider concerns that did not just involve the nation's health were beginning to appear by 1937. German rearmament caused government concern, and in an effort to avoid repetition of a lack of A-1 servicemen, the Physical Training and Recreation Act was passed in 1937. In 1939 it was announced that £1.5 million had been offered toward 865 schemes which involved £4 million on capital expenditure which

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[4] John E. Pater, *The Making of the NHS*, (London, 1981), p. 7.
[5] PRO FD 4/61 Medical Research Council Report, *Experimental Rickets*, 1921.
[6] PRO FD 4/68 Medical Research Council Report, *Rickets*, 1922.
[7] Richard Holt, *Sport and the British*, (Oxford, 1992), p. 344.
[8] PRO FD 1/3986 Medical Research Council Report, Physical Education and Applied Physical Training in Industry, 1937-1945.

would be used to develop '...playing fields, boy's clubs, youth hostels, gymnasia and expert leadership.'[9] But could the almost missionary zeal that supported physical exercise, and which was emerging in parliamentary reports, medical experiments and was promoted by bodies such as the Central Council of Physical Recreation, be applied to disabled people?

One of the key areas where the fashion for health and exercise did have a direct impact, was in the Army, where physical training was not only used to reduce the affects of disability, it was also used to prevent disability. Nowhere was this more evident than amongst the Forces, who required strong fit men for the nation's defence. Sub-standard Recruits Physical Development Depots were opened between the two World Wars and were in operation until 1939. Their purpose was to right the mistake of the First World War when Britain had been caught with a population of undernourished, unfit potential soldiers with poor physiques. Instead of being turned away, as previously, the Army embarked on a system of good food and physical training. [10] The report on the 'Sub-standard Recruit' detailed, 'Thereby was inaugurated an experiment in social medicine of vast importance, and few were aware at that time of its implications'.[11] With hindsight, the meaning was clear. The results of the Army's efforts were to provide more fit soldiers as the country prepared for war.

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[9] *British Medical Journal*, (June 3, 1939), p.1159.
[10] *The British Medical Journal*, (December 11, 1937), p. 1204.
[11] CMA SA/RBC C.7/4, Research Board for the Correlation of Medical Science and Physical Education 'The Sub-standard Recruit', 1943.

The Forces, and the whole impact of the First World War, as was illustrated in the previous chapter, of paramount importance to the perception and treatment of disabled people. A key development that had emerged during the treatment of the war wounded was the broader embrace of physiotherapy as a means of treating injury, and attempting to improve the mobility of disabled people. This preoccupation with health and residual disability thus extended to other areas of physical recovery. Physiotherapy was used to treat disablement and in recovery, and this allowed residual disability to be further minimised. Innovations in massage and physiotherapy had been practised during the First World War. It was after the War that physiotherapy began its first moves from a mere palliative treatment, to a more therapeutic and medical model.[12] Suspension with ropes and pulleys became more common after 1919.[13] This allowed the patient to practise performing exercises in a weightless environment and was later refined for patients with paralysis. Physiotherapy began to grow in popularity in the 1920s and in 1926, massage and electrical treatment were included in the benefits available to injured insured workers.[14] Physiotherapy and medical gymnastics, which was a type of drill but for recovery began to be associated with sport. Of course it did not suit all cases. Neurasthenia sometimes manifested itself in blindness and paralysis.[15] Perhaps because there was very little knowledge of this new and disturbing condition, physical education was not considered suitable for those

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[12] Elvira P.G. Hobson, *Physiotherapy in Paraplegia*, (London, 1956), p. vii.
[13] This method was devised during the First World War when a physiotherapist had to treat a paralysed patient who weighed 20 stones. The only way she could treat the patient was to suspend him with ropes and pulleys. Nellie L. Lanckenau, 'Rehabilitation by Modern Methods', William Brown Doherty & Dagobert D. Runes, (eds.), *Rehabilitation of the War Injured: A Symposium*, (London, 1945), p. 614.
[14] Jane Wicksteed, *The Growth of a Profession*, (London, 1948), p. 128.
[15] Wendy Holden, *Shell Shock*, (London, 1998), p. 7.

affected. Other groups who did not have exercise prescribed for them were those with heart disease, ulcers and arthritis. As there was very little knowledge of heart disease, it was not known if exercise would help patients or not. Children suffering from heart disease were 'naturally excused from physical exercises.'[16] Physiotherapists provided hydrotherapy and massage for those with arthritis, but not remedial exercise.[17]

Accompanying the development of useful advances in the treatment of disabled people, such as physiotherapy, was a strong residue of opinion that argued one of the aims of the medical profession was to cure disabled people. Such thinking saw disability as just another illness which could be remedied when the right treatment could be found.[18] For those that had a disability such as flat feet, or were simply malnourished, a solution to their plight could be effected. People whose disabilities were more severe were not going to be cured. However, since programs such as improving the health of the Sub Standard Recruits had been such a success, it seemed possible especially to the State, that exercise may be the panacea to other ills. Economic considerations also had to be taken into account. Works taken on such as the building of houses as a result of the 1919 housing act had cost the government a good deal of money. Exercise programs were a much cheaper option in the search for some kind of cure for disability. This notion that exercise would cure other social ills was evident in some contemporary

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[16] Colonel V.E. Gooderson, 'Physical Education in Special Schools', *Special Schools Journal*, Vol. 27, No. 2, (June 1937), p. 34.
[17] Wicksteed, The Growth of a Profession, (1948), p. 181.
[18] As supporting evidence for opening an orthopaedic hospital in Yorkshire it was argued that all disabled children needed surgery. PRO ED 50/172, Minute from A.H. Wood to L.G. Duke, 28 August 1923.

writing. Prunella Stack, daughter of Mrs Bagot Stack, founder of the Women's League of Health and Beauty, wrote about England having lost its happiness.

> And can we regain it merely by touching our toes, by exercising in harmony to music, while so many vast problems go unsolved, while bad housing, malnutrition and poverty all contribute towards the present standard of ill health? Yes I believe so – for this exercising is a beginning.[19]

Physical exercise was lauded, not only for its strengthening of the body, but also for the perceived value added moral fibre. For those exponents of physical health, it offered a panacea to a whole host of ills, Society generally would be a stronger and fitter place, while those 'unfortunates', the disabled could be improved by a programme of exercise. It seemed axiomatic that such exercises would benefit health.

Issues regarding the physical decline of perceived British superiority were also expressed through the theory of Eugenics; an idea that was familiar to many across Europe. Meaning 'good in stock', eugenicists preached sterilisation for those who were physically and mentally unfit. Social welfare was acceptable to many British eugenicists, but allowing these people freedom to have families of their own was not. As one contemporary commentator argued,

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[19] Stack, 'National Fitness', in Mayers et al, *Where Do We Go From Here?* (1938), p. 130.

> We now keep alive and tend carefully – quite rightly – the physically unfit, such as (a) epileptics, (b) consumptives, (c) the malformed, (d) weaklings, (e) deaf and dumb, (f) alcoholics; but, and this is the point to be realised, we also, quite wrongly, allow them to reproduce.[20]

Despite such claims, it should be remembered that eugenics, although part of an important ideological debate, was not widely influential in Britain, especially with respect to disabled people.[21]

Physical education had been considered important for the overall health of children since the late nineteenth century when physical drill had first begun emerging in the curriculum of many schools. Such exercises mainly consisted of drill, with children lined up in rows, bending and jumping to the commands of an instructor. From the turn of the century the benefits of play and games, particularly for younger children began to receive more support from authorities. At a conference held by the Childhood Society, it was suggested an important lesson was 'teaching the children in elementary schools how to play spontaneously'.[22]

There were arguments that exercise built good character and contemporary educationalists argued for a system which would make physical education for

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[20] Hawkes, 'What is Eugenics?', *Special Schools Quarterly*, Vol. 1, No. 2, (March 1911), p. 13. Interestingly, the blind are not included in this list of undeserving disabilities.
[21] For a discussion of the relative marginalisation of eugenicists see John Macnicol, 'Eugenics and the Campaign for Voluntary Sterilization Between the Wars', *Social History of Medicine*, Vol. 2, No. 2 (August 1989), pp 147-169.
[22] *The British Medical Journal*, (October 29, 1904), p. 1188.

children compulsory and 'would enable the State to assist in the development of genius.'[23] The Board of Education Syllabus from 1913, stated,

> It is especially during the period of growth when body, mind and character are immature and plastic that the beneficial influence of physical training is most marked and enduring.[24]

Physical fitness and good character were therefore closely linked. As one contemporary author concluded, 'It was not the athletic girl who was found hanging around a soldiers camp.'[25]

The drive towards a higher standard of physical fitness was apparent for the able-bodied, but what impact did such developments have on disabled children? They were not exempt from these moves to improve the fitness of the nation. From the deaf schools to the open-air schools this movement arrived to embrace many disabled children. Similarly, it was felt that the moral fibre of the disabled child, often perceived as loosely woven, would be improved by exercise. Physical activity should demand from the child 'a personal effort which develops his will and initiative.'[26] Poorly understood disabilities, such as epilepsy, were a target for the character reforming treatment of drill and exercise. At some schools for the epileptic, the children were given exercises to do every day, as part of the regime believed

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[23] 'Moral of the Unfit', *Special Schools Quarterly*, Vol. 5, No. 3 September 1915.p.58.
[24] Board of Education Syllabus, 1913 quoted in McLoughlin, *A History of the Education of the Deaf*, (1987), p.121.
[25] 'Moral of the Unfit', *Special Schools Quarterly*, Vol. 5, No. 3, (September, 1915), p. 58.
[26] M. Demeny, 'School Gymnastic According to Age and Capacity', *Special Schools Quarterly*, Vol. 9, Nos. 3 & 4, (September-December 1919), p. 27.

necessary to improve their physiques, as well as to control their weak constitution. It was argued that, 'Drill is very necessary to develop the muscular co-ordination so lacking in the epileptic'.[27] They also played games such as football, cricket and basketball all with the aim of improving muscular development, which it was felt was lacking in these children.[28]

Physical exercise mainly meant drill[29] and to a lesser extent Swedish gymnastics in the period before the First World War. Many schools adhered rigidly to a programme of remedial exercises, designed specifically for disabled children to build up compensatory muscles.[30] There was a straightforward belief that a stronger child would suffer less from the effects of their disability. Other schools continued to use the more traditional drill, for example girls at Chailey Heritage School were given drill practise four times a week.[31] Some schools were well equipped to practise physical culture in excellent facilities. At the Western Counties Asylum in Devon, the children performed drill and gymnastic exercises in their own gymnasium.[32] The open-air schools discussed in the previous chapter also used sport and games as a therapeutic method for the children who attended them. As well as physical and breathing exercises to develop muscles, children were encouraged to

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[27] 'Education at Chalfont Colony School for Epileptics', *Special Schools Quarterly*, Vol. 2, No. 3, (September 1912), p. 64.
[28] People with epilepsy living at Chalfont Colony displayed 'prowess at outdoor sports'. *The British Medical Journal*, (October 29, 1904), p. 1181.
[29] For more details on drill see Frank Galligan, *The Development of Gymnastics in the West Midlands, With Partial Reference to its Association With Religious and Educational institutions During the period 1865-1918*, unpublished PhD Thesis, Coventry University, 2000.
[30] Remedial exercise programmes with few games were practised at schools like the Lancasterian School for Physically Defective Children which was opened in 1908. *The Special Schools Journal*, Vol. XXI, No. 1, (February 1931), p. 21.
[31] PRO ED 62/76 Board of Education Reports: Chailey Heritage, 'Arrangements for Special School Continuation Courses Report', May 17, 1918.

play as well as rest. Half the day was devoted to lessons and the other half to a combination of games, exercises and sleeping. Although the children were encouraged to play, there was a competitive edge to their games. Throughout the year, the open-air establishments held rounds of competitions where the children vied for prizes in races. Sports days with other open-air schools regularly took place, where the usual round of games were played, and three-legged races and sack races run. Outdoor physical exercise was little reduced in winter, with the children put outside to skip in the rain and wind.[33] The regime was not all fun and games for all children however. It has been suggested that in some cases the children's 'physical activity' took the form of manual work around the school.[34] As well as this form of exploitation where children worked rather than played, provision of facilities for activities for disabled children were not always forthcoming. In 1921 after local authorities had been compelled to provide for blind people under the Blind Persons Act of 1920, the London County Council still refused to provide access to swimming pools for blind children under its care.[35] This refusal to take responsibility for physical recreation for disabled children was not always the rule, many authorities provided what they could afford.[36]

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[32] Ernest W. Locke, 'The Work of the Western Counties Asylum, Starcross', *Special Schools Quarterly*, Vol. 2, No. 2, (June 1912), p. 37.
[33] Lewis Williams, 'Open-Air Schools', *Special Schools Quarterly*, Vol. 3, No. 1, (March 1913), p. 16.
[34] For example a swimming pool had been filled with rubble and the children had to carry and spread 50 bags of soil to turn it into a garden. Frances Wilmot and Pauline Saul, *A Breath of Fresh Air*, (Chichester, 1998), p. 82. The children at Chailey built Kitchener huts for their own accommodation so that the wounded soldiers of the First World War could have the main building, C.W. Kimmins, *Chailey Heritage 1903-1948,* (London, 1948), p. 8.
[35] *The Lancet*, (December 3, 1921), p. 1190.
[36] There was a wide range of provision of both facilities and equipment. For details see John Welshman, 'Physical Education and the School Medical Service in England and Wales, 1907-1939', *Social History of Medicine*, Vol. 9, No. 1, (April 1996).

While drill and breathing exercises were considered proper for children in open-air or local authority schools, disabled public school pupils played games similar to those played in able-bodied public schools.[37] Worcester College, the public school for blind boys, had a highly rated rowing team.[38] Their first victory against a sighted team was in March 1918, when their first fours beat the Royal Flying Corps cadets.[39] Later that year, they held another Regatta, this time against the officers from St Dunstan's.[40] At Chorleywood, the school for blind girls, netball, tennis and swimming were played.[41] As well as these more traditional activities, a new game was devised in 1922 by the headmistresses at Chorleywood, who had taught at Roedean, which was a combination of netball and football called Sport X.[42] Like the boys at Worcester College, the girls at this institution also played against sighted schools. Similarly to public schools for the able-bodied, the stress on competitive games and exercise was evident in the blind institutions.

During the 1930s, physical education at schools for disabled children experienced a fundamental change. In 1933, a new syllabus for physical training was introduced by the Board of Education in an attempt to further improve the fitness levels of all school children.[43] As Sir George Newman architect of the School Medical Service, wrote in the preface,

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[37] Until 1926, the only two public schools for disabled children were Worcester College and Chorleywood, which were for blind pupils.
[38] *National Institute for the Blind Annual Report, 1936-1937*, p. 37.
[39] It is interesting to note that only officers from St Dunstan's were considered worthy opponents of boys at a public school. *The Beacon*, Vol.2, No. 17, (May 1918), p. 4.
[40] *The Beacon*, Vol. 2, No. 20, (August 1918), p. 11.
[41] *National Institute for the Blind Annual Report 1931-1932*, p. 29.
[42] June Rose, *Changing Focus: The Development of Blind Welfare in Britain*, (London, 1970), p.101.
[43] PRO ED 50/249 Board of Education Pamphlet *Suggestions in Regard to Games* (London, 1920), made no reference to physical training or activities for disabled children.

> Suitable nourishment, effective medical inspection and treatment, hygienic surroundings, however excellent, will not of themselves build up a sound physique. Physical exercise is also required. In exceptional conditions of unemployment, poverty or economic distress, it is particularly necessary to safeguard mental and physical health by means of wisely directed physical education of the body, which will lay the foundations of wholesome out of door recreation, as well as protect normal growth, health and strength.[44]

It was obvious that by placing the responsibility for health on exercise and fitness that Newman was not prepared to blame the shortcomings of unhealthy children on the School Medical Service.[45]

Whilst the beneficial affects of exercise for the body's health was well established for both disabled and able-bodied children by this time, the Syllabus contained another more important reference. For the first time, disabled children were included as a specific group within the Syllabus.

Although the Syllabus is intended primarily for the normal child it can also be used with appropriate modification in schools for the mentally and physically defective children. Physical exercises form an important part of the education in these schools. As far as possible the afflicted

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[44] Board of Education, *Syllabus of Physical Training for Schools*, (London, 1933), preface.
[45] Welshman, 'Physical Education and the School Medical Service', *Social History of Medicine*, (1996), p. 47.

> child should be encouraged to ignore physical disability and to follow as much as possible of the normal programme.[46]

Disabled children were able to participate more fully in the activities of the Syllabus because, again for the first time, many of the exercises were adapted to the sitting or lying down position.[47] This innovation enabled wider participation, especially for physically disabled children for whom standing was difficult.

Journals for special schools shared this enthusiasm for physical education, and published articles to extol the benefits of exercise to their readership. A programme of remedial exercises was replaced with other activities, for example, a combination of drill, games and dancing.[48] At Chailey Heritage School, for example, a one and a half-hour session of Margaret Morris dancing and movement was held once a week.[49] A varied routine of exercises for schools was an innovation, yet the primary function of physical education for disabled children was the maintenance of their health. It was asserted that exercise would inhibit further physical deterioration due to disability, as well as correcting physical defects, so it was regarded as a

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[46] Adaptations for blind, deaf and 'crippled' children were suggested. Board of Education, *Syllabus of Physical Training for Schools*, (1933), p. 24.
[47] Originally these exercises in recumbent positions were not designed for disabled children, but for 'younger children' in order to prevent unnecessary movement of the spine. Board of Education, *Syllabus of Physical Training for Schools*, (1933), p. 201.
[48] A Thorp, 'The Scope and Practice of Physical Education in Special Schools', *The Special Schools Journal*, Vol. 24, No. 3, (October 1934), p. 66.
[49] PRO ED 62/76, Board of Education Reports: Chailey Heritage, 'Time-table for Housewifery Training', (no date, presumably 1933).

significant preventative treatment.[50] Physical well being was still inextricably linked to mental health, as we have seen earlier in the chapter, and this remained an important consideration in relation to disabled children.[51]

So far, the discussion of sport for disabled children has centred on those in segregated schools. For disabled children attending able-bodied schools, problems with exercise was much more individual as sometimes allowances were made for their disability and in other cases they were not. Teachers in able-bodied schools were not adept at recognising disability, and often unaware of a disabled child in their class, simply labelled them 'slow'. Marie Hagger who was deaf and attended an able-bodied school, discussed her experience.

> I was good at gymnastics and things like that but they weren't interested in these. It was the outdoor sports that earned you merit...I would line up with all the others...I'd wait for the others to run and then I'd run – and come last of course.[52]

For others like Louis Goldberg, who had cerebral palsy, and attended school in the 1920s, sport at school was a more positive experience.

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[50] PRO ED 24/2097, 'Memorandum of Physical Education', Minutes from British Medical Association, Training of Teachers Sub-Committee, April 1st, 1935. See also *The British Medical Journal*, (January 16, 1937), p. 134.
[51] Gooderson, *The Special Schools Journal*, Vol. XXVII, No. 2, (June, 1937), p. 29.
[52] The reason that Marie's teachers did not realise she was deaf was that Marie was determined they should not find out as she was terrified that she would be sent away from home to a deaf school. Humphries and Gordon, *Out of Sight*, (1992), p. 53.

> Our headmaster was an ex-professional footballer. I was the only disabled child in the school so on the first day he got me into his office. He wasn't nasty, he just said that just because I was disabled I wouldn't be let off anything...If we were playing cricket I could join in a bit. If it was football I looked after all the boots and the kits and when the others were boxing I was made referee. They even tried to teach me to swim a bit. I used to enjoy it, being made a part of it all.[53]

Outside the school gates there were few after hours activities available for disabled children especially if they had problems with their mobility. After the First World War local councils set up Cripples parlours where disabled children could gather once a week to play games like dominoes and cards.[54] Clubs such as these did not provide extra exercise for the children, but there was a recreational activity which gained popularity in the early part of the century, and where disabled children were welcomed. This was the scouting movement. By 1925 there were eight troops of blind and partially sighted scouts in Britain.[55] There appeared to be very little co-ordination of how to teach blind children the methods of scouting, but the ad hoc method of adapting the awards appeared to be successful. By the end of the 1920s the guide movement for blind girls was popular and many schools for the blind had their own guide troops. Blind girls at the Royal School for the Indigent Blind in Leatherhead had its own girl-guide pack as well.[56] The movement was considered beneficial to disabled children as well and scout and guide

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[53] ibid, p. 49.
[54] Humphries and Gordon, *Out of Sight*, (1992), p. 44.
[55] *The Beacon*, Vol. 9, No. 106, (October 1925), p. 14.
[56] *The Beacon*, Vol. 12, No. 136, (April 1928), p. 9.

groups were established for them. All disabled groups joined in the very popular movement. There was a scout group at Oswestry in Shropshire in the late 1920s.[57] Chailey Heritage, the home for crippled boys and girls had their own guide pack, the headquarters of which were opened by Lady Baden-Powell.[58] Disabled children were enthusiastic members of the scouting movement.

As we have seen from the outdoor recreational movements such as scouts and guides and the prevalence of open-air schools, the cult of fresh air and the idea of freeing children from the confines of the smoggy cities was popular and continued throughout the 1930s. During that time, many disabled children were sent to outdoor camps, especially those living in larger cities such as London. The lack of fresh air and space to play was understood to have a debilitating affect on the urban disabled child. The *Daily Telegraph* reported on a camp in Hampshire for blind children, which provided an opportunity for playing games in the fresh air.[59]

Throughout this period sport and physical exercise was used as a way of keeping children healthy, and in an attempt to reduce the effects of disability. As the years progressed educationalists, especially those in schools for the disabled, realised that while such exercise was beneficial it had to be tailored for the given and specific disability. This was the key lesson of the inter-war

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[57] Jones & Hunt, *The Heritage of Oswestry*, (1961), p. 76. Kimmins, *Chailey Heritage,* (1948), p. 31.
[58] Kimmins, *Chailey Heritage,* (1948), p. 31.
[59] *Daily Telegraph,* (June 19, 1933)

years.

While the authorities tried to ward off impending disability and reduce the affect of existing ones in children through drill and exercise, this therapy was also used on disabled ex-servicemen. Thousands of men returned home, as we have seen in the previous chapter, with body parts missing and senses permanently damaged by the war. After the war was over, part of the job of the Ministry of Pensions and other voluntary associations was to give to these disabled men, in some way, opportunities to return to their pre-war lives: 'It is our duty to put him back, to restore him, in fact, to society healed and mended in body and mind as far as possible'.[60]

The previous chapter discussed this restoration in terms of training for jobs, preferential employment schemes and pensions. Whilst these concessions were of vital importance, and gave the war wounded back some semblance of previous life and a just reward for their suffering, there were other, less obvious considerations of restoration to a previous life. While the able-bodied soldiers and sailors continued to play sport as part of the Services culture, efforts were made to provide those who had suffered serious injury resulting in disablement.

Endeavours were made during the First World War to organise local sporting events in which the war wounded would feature and there were efforts to

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[60] Article by Sir Arthur Griffith-Boscowen, Parliamentary Secretary to the Ministry of Pensions in the *War Pensions Gazette*, October 1917. Quoted in Devine, *Disabled Soldiers and Sailors*, (1919), p. 177.

publicise disabled ex-servicemen playing games and performing other physical activities. *Country Life,* for example, reported on 'the glorious pluck and cheerfulness' of the amputees who were patients at Roehampton Hospital as they played variations of football and tennis in the grounds.[61] Sporting competitions for disabled ex-servicemen were held in various locations, as a way to raise money for the institutions, and for the wounded to enjoy having a day out participating in a game. Sometimes they played against able-bodied teams. An example of this was in August 1917 when the 'Arms and Legs', which referred to soldiers who had suffered amputation, were invited to play cricket against a local team.[62] In his diary, a local schoolmaster reported the day's events.

> I stood and watched for a time but it was too worrying to me to see a man on one leg trying to bat though our captain told the bowlers to bowl easy balls. Some of the women cried to see them but they were as cheerful as Crickets and hopped on one leg from the Pavilion with their one leg and without crutches.[63]

Why did so many of these young men with severe injuries want to exhibit themselves to a curious public just to play games? There is so far no evidence to suggest that there were particular instructions from the War Office, ordering games to form part of the regime for disabled ex-servicemen.

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[61] *Country Life*, (August 14, 1915), p. 241. [61] Imperial War Museum Document Archives 79/15/1, Diary of R. Saunders.
[62] Imperial War Museum Document Archives 79/15/1, Diary of R. Saunders.
[63] IWM Document Archives 79/15/1, Diary of R. Saunders.

It may have been that since sport was such an accepted part of life in the -3+. Services, a resumption of games would have been presumed by those in charge. Many of the men had been young and physically active before being injured during the war. In general the fittest and strongest had gone to fight. They had probably played and watched sport and in other ways had led fairly physically active lives. When they returned, some of them were blinded, deafened or missing parts of their bodies. Although the war had left a permanent legacy with some of them, the inclusion of some type of adapted physical recreation seemed to offer an opportunity to resume as full a life as possible after the upheaval of war. The playing of sport or resumption of some type of physical activity was one way that a young disabled man could re-establish his masculinity, and demonstrate that his disability had not changed him.[64] F.W. Heath, a publisher and journalist, made special reference to the assistance that his concentration on sport had given him after his arm had been amputated.

> Looking back, I realize that I was wise in concentrating on games. However indifferent some of my efforts may have been they gave me back confidence in myself, and new health and strength.[65]

There were other factors that also need consideration, including boredom. Many of these men were patients for an extended period of time, and games

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[64] There is currently PhD being undertaken at Essex University by Wendy Gagen on disability and masculinity in the First World War.
[65] F.W. Heath, 'One of the Lucky Ones', Ian Fraser, (ed.), *Conquest of Disability*, (London, 1956), p. 196.

provided a diversion from the monotony of hospital life. Sports days in hospitals like Roehampton, which held its first in 1916, provided not only a crowd of visitors, who might be impressed by the men's prowess with their artificial limbs, but the gate receipts went toward maintenance of the hospital.[66]

While those in the War Office had not issued orders that sport might be used for the recovery of disabled ex-servicemen, doctors were quick to make use of games for both their physical and mental recovery. At the Prince of Wales Hospital in Cardiff, for example, one of the doctors had a golf course constructed for amputees, with bunkers, bridges, stiles and gates.[67] While playing a round, men with artificial limbs were able to practise with their new appliances, and the course was a far more stimulating and pleasant training ground than a hospital gymnasium. Other games provided a more entertaining way to become more active, for instance stoolball was revived in 1917 as a game for wounded soldiers.[68] At hospitals, both nurses and well-to do were organised to play stoolball games with the patients, and a tournament between them was organised which was held at Lords annually until 1927.[69]

After the war was over, disabled ex-servicemen continued to play and publicise their games. St Dunstan's promoted itself in order to pay for the high level of service it provided for its blind inmates. The home regularly placed

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[66] Alper, *A History of Queen Mary's University Hospital Roehampton*, (1997), p. 11.
[67] Robert Tait MacKenzie, *Reclaiming the Maimed*, (New York, 1918), p. 91.
[68] The game closely resembled a less formal form of cricket, the ball is bowled underarm and the wicket is stylised, about 1.4 metres high and had a board attached to it.
[69] John Lowerson, 'Stoolball and the Manufacture of "Englishness"', in Pfister et al., *Games of the World Between Tradition and Modernity*, (Sankt Augustin, 1993), p. 411.

press advertisements seeking funds, and even marketed its own brand of cigarettes to raise capital. In March 1920, some of the blind athletes at St Dunstan's gave a half hour display to a group of journalists of rowing, putting the shot, throwing a cricket ball, 100 yards sprint and football kicking, rope climbing and a tug of war.[70] Other special events were staged for distinguished guests such as royalty, providing both groups the means to present themselves positively to the public. When Prince Albert went to St Dunstan's in 1920, he saw a demonstration similar to that of the newspapermen some months before.[71]

As well as providing assistance with pensions the British Legion also publicised the sporting exploits of its members. On July 14, 1923, it held an Imperial Sports Rally[72] at the newly opened Wembley Stadium[73] ostensibly an event for those ex-servicemen of the empire who had returned from the war without any permanent injury. The events for disabled ex-servicemen included a mile walk and a 100-yard race for the blind, and a 250-yard race for single leg amputees, both an individual and a team event.[74] The turnout was relatively small and the stands appear sparsely filled with what are other competitors, ex-servicemen and a few members of the public.[75] Even the presence of the Prince of Wales to hand out the prizes, had little impact on

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[70] *St Dunstan's Review*, Vol. 4, No 43, (April 1920), p. 11.
[71] *St Dunstan's Review*, Vol. 4, No. 45, (June 1920), p. 10.
[72] *The Times* referred to the event as the Empire Sports and the British Legion named it the Imperial Sports Rally.
[73] This was only the second time that Wembley Stadium had been used for a major event. The first had been the Cup Final in April. *The Times*, (July 16th, 1923).
[74] *The Times*, (July 14th, 1923).
[75] Photographic plates at Queen Mary's University Hospital Roehampton.

the public's attendance.[76] The event was not repeated and while the British Legion continued to support the sport clubs and endeavours of its membership, it did not organise any similar competitions again.[77]

The homes that provided ex-servicemen with their different disabilities a place to re-train, or take up residence, also provided sporting outlets for the men. Two examples of the largest and most influential homes for disabled ex-servicemen will be examined, to explore how each one treated sport. Both St Dunstan's and the Star and Garter Home have long histories.[78] These are important as they provide essential details about how these institutions operated, and how they changed over time. As we saw in chapter one, St Dunstan's opened in 1915 and was specifically for blind ex-servicemen. It is a particularly interesting example of the way sport and games were used to restore masculinity to wounded ex-servicemen, but also for the level of commitment with which these blind ex-servicemen took up sport, not only for their own health, but also to promote the interests of the home. In the early days when it first opened, in late 1917 and early 1918, physical exercise took the form of organised rambles which would be 'beneficial to the health of the boys'.[79] Swedish exercise was also practised. Rambles and Swedish gymnastics were soon eclipsed in popularity by more masculine sporting pursuits. Rowing at a very competitive level grew to be very popular amongst

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[76] Businesses provided donations to pay for the entry fee of disabled ex-servicemen and unemployed officers. They included companies such as Kodak, Boots and Eyre and Spottiswoode. *British Legion,* Vol. 2, No. 14, (August, 1923), p. 53.

[77] The Legion continued to support the various sporting clubs formed by its members, including football, billiards, cricket and tennis, although there is no specific mention of sporting clubs for disabled ex-servicemen. *British Legion Journal*, Vol. 10, No. 3, (September, 1930), p. 71.

[78] Both St Dunstan's and the Star and Garter Home still exist today.

[79] *St Dunstan's Review*, Vol. 2, No. 18, (January 1918), p. 23.

blind ex-servicemen, and by May 1918, there were 48 boats on Regents Park Lake that the ex-serviceman at St Dunstan's used for training and racing.[80] The first of what became an Annual Regatta was held at Putney in 1918 and the enthusiastic crowd who attended these events were especially keen on the blind one-armed races.[81]

Rowing was not the only sport in which there were contests, in fact many of the physical activities had a competitive edge. Tug of war assumed a special importance at St Dunstan's as the Pearson Challenge Cup was awarded every year to the winner of the inter-house competition.[82] Athletic competitions were also held, and the Saturday Sports, as they were known, would attract over 200 entries a week. Competitions included running races at which a wrist rope attached to a wire stretched along the track would enable them to compete. They would be warned of the approach to the finish by a bell. Other sports included putting the weight, skipping races, and rope climbing.[83] Sport and training were taken seriously; the boats were on Regents Park Lake at six o'clock in the morning. For those not interested in boating, physical training was held every morning at seven.[84] When a Sports Day was imminent, one ex-serviceman recalled, that additional preparations were made to reach the peak of fitness including, 'much extra physical effort, and much extra training, cold showers and massage'.[85]

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[80] *St Dunstan's Review*, Vol. 22, No. 2, (May 1918), p. 11.
[81] *The Beacon*, Vol. 4, No. 44, (August 1920), p. 9.
[82] Each house at St Dunstan's was divided into a sporting group. They had names such as Bungalow Annexe.
[83] The rope climbs were varying heights, but included one of 90 feet. James Tindal Scrymgeour, *Reminiscences of St Dunstan's*, (Devon, 1920), p. 70.
[84] *St Dunstan's Review*, Vol. 3, No. 29, (January 1919), p. 14.
[85] Scrymgeour, *Reminiscences of St Dunstan's*, (1920), p. 68.

As with athletics and rowing, there was an Inter-annexe football competition. The term 'football' should be applied loosely to this early game, as it did not resemble the standard able-bodied game, but was played more like the modern penalty shoot out. Teams consisted of three semi-sighted, three totally blind men and a sighted goalkeeper.[86] The game was played in two halves, in which team members would have two attempts at kicking a goal. Although the game did not change for the final, the usual sighted goalkeepers would be exchanged for a sporting celebrity. Usually a famous football goalkeeper would be invited to attend, which meant a report and some photographs in the newspaper. *The Times* reported,

> A soldier who played football while in the Army cannot get away from the desire to have a kick at the ball, even though he is sightless...goal kicking by the blind has been developed there into a popular and even exciting sport.[87]

In 1920, the goalkeeper was Chelsea Football Club's Molyneux. In 1921, both Arsenal's goalkeeper Williamson and the English international referee, Rutherford were in attendance.[88] After the St Dunstan's Cup Final was over, the Arsenal team were then blindfolded and played a game of the St Dunstan's version of football.[89] St Dunstan's continued to use games to promote itself, and coupled with the combination of support for disabled

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[86] *St Dunstan's Review*, Vol. 4, No. 39, (December 1919), p. 14.
[87] *The Times*, (February 26th 1920).
[88] *St Dunstan's Review*, Vol. 5, No. 53, (March, 1921), p. 15.
[89] Ibid.

soldiers, and the sympathy the able-bodied felt towards the blind they were very successful.

Blind ex-servicemen from St Dunstans continued to participate in an ever increasing range of activities. Walking became a favourite recreation and from the rambles mentioned earlier in the chapter, a competition developed and continued to be popular for a long time after its inception. The first race for the St Dunstaner's was held in December 1920 when the men walked the three miles around the Outer Circle of Regents Park.[90] The pathway around the Park was to become an often-used measure of champion walkers. A walk to Brighton in October 1922 was successful and paved the way for increased distances and competitive events.[91] With this achievement behind them, the blind at St Dunstan's in particular were one of the first disabled groups to look for recognition of their sporting prowess by the able-bodied. In 1924, a suggestion was made to the Amateur Athletics Association (AAA) that blind athletes should participate in open walking events.[92] There was resistance to this from the AAA because the blind required an escort, which was against the rules of able-bodied competition. Longer-distance running races were experimented with in 1925,[93] but were never as popular as the walking competitions.

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[90] *The Beacon*, Vol. 5, No. 49, (January 1921), p.13.
[91] *St Dunstan's Review*, Vol. 7, No. 70, (November 1922), p. 7.
[92] *St Dunstan's Review*, Vol. 10, No. 104, (December 1924), p. 28.
[93] *St Dunstan's Review*, Vol. 9, No. 99, (June 1925), p. 16.

St Dunstan's had their own official system of awards. For participation in a race, a man was entitled to a St Dunstan's Athletic Club badge.[94] For those that had excelled at a sport, for example the winners of the Pearson Challenge Cup, award ceremonies were held, usually at an evening function and were clearly a special occasion.

Even after the war had faded from the forefront of the public's mind, St Dunstan's continued its work which was often recognised in the press. Their sporting exploits were still publicised as they joined with the ranks of the able-bodied in walking competitions. The previous problems with the AAA were overcome and the blind men were allowed to participate in the able-bodied Stock Exchange races with an escort in the 1930s. From December 1931 to May 1932 there were no less than six official walking events, including a six mile outer circle walk, a three mile novice walk, a nine mile outer circle walk, a fifteen mile outer walk and an annual walk in Birmingham. The blind required escorts for these activities, and they were provided from a host of sighted people, from officers in the Metropolitan Police to members of the Stock Exchange.[95] Not only assistance with guides, but facilities continued to be offered to the men at St Dunstan's. The Marylebone Baths was open for use by the ex-servicemen at St Dunstan's and swimming competitions were held there throughout the 1930s. Ian Fraser commented on the benefits.

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[94] *St Dunstan's Review*, Vol. 2, No. 21, (April 1918), p. 25.
[95] *St Dunstan's Review*, Vol. 17, No. 182, (January 1933), p. 8.

> There's something about swimming which is quite unique when you're blind – it is the fact that you can move about as vigorously and as fearlessly as you like in any direction without any fear of hitting anything.[96]

The other example of sporting exploits at a home was the experience of those at the Star and Garter Home in Richmond. Like St Dunstan's the residents at the Star and Garter Home were interested in playing sport. However, unlike St Dunstan's the group at the Star and Garter were not a completely cohesive disabled group; they had differing disabilities, and did not benefit from the preferential treatment and high profile meted out to the blind. In many cases, prostheses ware cumbersome and did not lend themselves to lively movement. One ex-serviceman who had undergone amputation remarked,

> The loss of a leg on the Western Front in 1918 was a considerable loss to me whose chief recreations were swimming and walking. I could still swim, but walking is no fun to a man with an artificial leg which feels, when he is tired, as if it were a ton in weight...[97]

Despite these difficulties, the Star and Garter residents did take up exercise. On November 11th 1920, they formed their own Star and Garter Sports Club, its main objective to, 'Enable both Staff and patients to join in all games that

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[96] Fraser, *Whereas I Was Blind*, (1942), p. 38.
[97] Ervine, 'We Must Grin and Bear It', Fraser, *Conquest of Disability*, (1956), p. 82.

are possible, thereby encouraging a feeling of comradeship between them'.[98]

Games offered both fun as well as something to while away the time.[99] For those who could move around, either with prosthesis or a wheelchair, games could be much more diverse and included tennis, bowls and croquet.[100]

> I do not see why croquet should not be played by the Patients as well as the Staff, certainly those boys who can walk could play, and I have known croquet to be played from a wheelchair; it may not be good for the lawn, but that does not matter as long as it gives pleasure.[101]

As with St Dunstan's and Roehampton, the Star and Garter put its patients and their sporting achievements on show to the public. A Sports Day for their residents was first held in 1923 when the patients took part in races, including in their wheelchairs, obstacle zigzag.[102]

Disabled ex-servicemen were often on the lookout for sports that they could play on equal terms against other able bodied people. As we have seen, the blind men of St Dunstan's took part in walking competitions with the able-bodied. Although able-bodied men could play at a less aggressive level, as evidenced by the Arms and Legs cricket match mentioned earlier in the

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[98] *Star and Garter Magazine*, Vol. 1, No. 1, (January 1921), p. 27.
[99] For those that were bedridden, games such as whist, bridge and chess were played.
[100] The first time croquet had been played in wheelchairs was probably in 1920 when a group of disabled ex-servicemen from the Queen Alexandra Hospital Home played their first tournament Farrant, *The Queen Alexandra Hospital Home*, (1997). p. 43.
[101] *Star and Garter Magazine*, Vol. 1, No. 1, (January 1921), p. 28.
[102] *Star and Garter Magazine*, Vol. 3, No. 4, (October 1923), p. 192.

chapter, there was more suitable competition for disabled war veterans. Women were sometimes called upon to play team sports against them. It may be that a lack interest from able-bodied males prompted this initiative and it certainly had social benefits. It may also have been part of the charitable work that women did, visiting disabled ex-servicemen. At the Star and Garter Home, from 1928 an annual cricket match was held between the Home and the Folkestone Ladies. The game was slightly altered with no running between the wickets 'to prevent the patients overtaxing their strength'.[103]

In the 1930s, the fashion for physical exercise was particularly evident at the Star and Garter Home. A special room, full of equipment was provided to ensure that the patients were able to exercise their bodies. It is evident that some of the men subscribed to the contemporary idea that exercise may limit or even improve their disability. Repetitive remedial exercises may not have proved popular. As the magazine from the Home reported,

> The faithful band of those who are hoping for improvement, and those who at least believe that the regular exercise keeps them from any further deterioration in their limbs, begin to line up outside the door of the gym.[104]

While it appeared that disabled ex-servicemen, particularly the blind and others in an institutional setting could indulge their sporting desires, and it was

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[103] *Star and Garter Magazine*, Vol. 8, No. 3, (July 1928), p. 119.
[104] *Star and Garter Magazine*, Vol. 14, No. 1, (January 1934), p. 20.

an important part of the curriculum for children particularly during the 1930s, the civilian disabled had to cater for their own needs. Like their ex-service comrades, the civilian blind also held organised sporting events, but these tended to be more local and were not developed as early as those for the war injured. A Sports and Social Club was established by the National Institute for the Blind in 1919.[105] It was important, not only from the point of view of fitness, but also again for its social impact. These events were a chance for disabled groups to get together and enjoy a day's outing. Other types of exercise were taken up by the civilian blind including Margaret Morris's dancing and remedial exercise to music, which was much more lively and interesting to do than repetitive drill.[106] Blind people at the National Institute held a display of this marching and physical exercise in London in 1927.[107] The social events were given less prominence and the fitness and games were brought to the fore when the National Sports League for the blind was established in 1930.[108] At first the clubs limited events to swimming and rowing, but the programme was gradually extended to include other activities. As well as sporting competitions, there were games nights in which draughts, chess and card games featured, and dances.[109] Dancing meant physical proximity between men and women, which helped to socialise them and often could be the first steps to sexual contact. The sporting events were not limited to men. Blind women also took part in sport, throwing the hammer and running in

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[105] *The Beacon*, Vol. 4, No. 43, (July 1920), p. 10.
[106] Margaret Morris described her movements as 'A method of Physical Education and Creative Dance combining therapeutic and aesthetic values.' Margaret Morris, *Creation in Dance and Life*, (London, 1972), preface. See also Margaret Morris, *My Life in Movement*, (London, 1969) and Joan W. White, *Margaret Morris: A Prophet Without Honour*, (Glasgow, 1980).
[107] *The Beacon*, Vol. 9, No. 122, (February 1927), p. 14.
[108] *The New Beacon*, Vol. 14, No 160, (April 1930), p. 65.
[109] *The New Beacon*, Vol. 14, No. 166, (October 1930), p. 210.

races at several events in Manchester in 1936.[110] The National Institute held other sporting competitions that featured rowing, swimming and tennis, as well as rambling, but since these were the activities of the civilian blind and not the activities of the war-disabled there was little public interest in them.

As a contrast, it is clear that fitness was not an issue for all. To sporting activists, the Blind March of 1936 discussed in the previous chapter was not a celebration or public display of the blind's fitness. Quite the contrary as many of the participants were unable to walk all of the way to London, despite having passed a fitness test in order to be included.[111] As reported in a National League of the Blind report on the event,

> This was only to be expected in view of the fact that normally blind people do very little walking and most of the workshop occupations are more or less sedentary.[112]

While it can be suggested it would be difficult for many able-bodied individuals to walk from the north of England to London, this demonstrates the difficulty in demonstrating how widespread exercise and other activities were to blind people. It appears that any consideration of the disabled, physical exercise and rehabilitation must be aware that many disabled people did not, or could not avail of regular sporting or other physical activity.

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[110] *Manchester Guardian*, (June 2nd, & June 27th 1936).
[111] No women were selected to go on the march. *North Mail*, (23rd September 1936).
[112] PRO MH 55/590, Memo from V.L. Harkness to Mr Roundell, GI District re: Blind Marchers, 1936.

Whilst the blind established their own games and activities, other disabled groups, while not as organised as the blind, still managed to engage in activities providing both a social and physical outlet. These efforts were mainly local, for example, in 1938, a social club for physically disabled people was established in Coventry. In its first year it organised a series of games with a group of disabled people from Leicester.[113] Named the Enterprise Club, it was originally for boys who were unable to join in the more physical forms of exercise that were played in the boys clubs. Although many of these early games were played indoors such as billiards, there was later some outdoor sporting activity like archery. Owing to the difficulties of transport, the competitions between cities were not as regular as the participants may have wished, but whenever possible the social and sporting competitions were organised.[114]

Despite the upsurge of physical exercise for disabled children in schools in the 1930s, and the constant efforts of the war disabled, exercise and games did not spread to the civilian disabled as rapidly. There may have been specific reasons for this. In the *National Cripples Journal*, one of the purposes of the group as we saw in chapter one, was to appeal to Christian men and women to assist them by subscribing to the journal, but the other group that was singled out as potential benefactors were sportsmen 'who enjoy games we cannot'.[115] Since the journal had to rely for funds on door-to-door sales and subscribers, sympathetic to the plight of physically disabled people, sales

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[113] *The Coventry Cripples Social Club*, (1943), p. 8.
[114] Interview with Len and Peggy Tasker, April 1998.
[115] *National Cripples Journal*, No. 7, (January 1931), p. 1.

may have been reduced by articles about disabled people robustly enjoying games and sporting pursuits.[116]

While the *National Cripples Journal* steered away from sport, possibly from fear that it would affect donations, sporting competitions were used by charities in order to raise money for disabled people. Raising money could take several forms. We have already seen how homes and hospitals used sports days as fundraisers and also sought donations for sporting equipment and facilities. Able-bodied sporting events were also a way of raising money for homes. Sometimes, publicity would awaken the public's interest in an institution, for example a famous sporting personality would visit and it would provide extra impetus. Famous sportsmen occasionally lectured to disabled children on sport. Gus Platts, who was a leading boxer in the 1920s, went to the Sheffield School for the Blind to give the students instruction in boxing.[117] Charities also provided disabled children with sporting equipment, as often what was provided for them was poor or non-existent. One of the reasons that they had difficulty playing sport was that their clothing and footwear was often not suitable in which to play.[118] Making appeals for sporting equipment became a regular feature of many institutions. In the 1930s, when the *Manchester Guardian* collected for their 'sports gear appeal', they also collected for disabled schools. A school wrote to thank the paper for the bats

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[116] Before the Second World War there are no articles about disabled people playing sport. This is particularly interesting as Len Tasker, of the Enterprise Club in Coventry was involved in the *National Cripples Journal*, becoming its editor on Len Inskip's death in 1955.
[117] *The Beacon*, Vol. 4, No. 41, (May 1920), p. 9.
[118] *The Special Schools Journal*, Vol. 24, No. 3, (October 1934), p. 65. See also Welshman, 'Physical Education and the School Medical Service ', Social History of Medicine, (1986), p. 41.

and balls that they had received, 'The letters show that games, and rhythmic exercises, for which balls are required, play an important part in the lives of crippled children.'[119] Philanthropy could involve provision of sporting facilities on a larger scale. In 1938 a playing field and cricket pavilion was presented to the Boys Heritage School at Chailey.[120] Charitable Acts were not limited to gifts of equipment: able-bodied children were organised to play games with disabled children. Girls from Roedean and St Mary's Hall played stoolball against the pupils at Chailey Heritage School.[121] Whether the donation or activity was large or small, sport was a regular focus of charity for disabled children.

The war disabled benefited from the immediate post war philanthropy and with their enhanced 'war hero' status, were the objects of sporting goodwill on a regular basis. St Dunstan's was a regular recipient. In July 1920, an August bank holiday day of athletics was held to benefit those at St Dunstan's. The advertisement in *The Athletic News* exhorted all potential athletes to 'enter at once and support our Blind Heroes'.[122] While events such as these were well intentioned, there were complaints that such charity games were not benefiting good causes as much as they might, as charges for refreshments, the watchman and tax were eating into the receipts.[123] Boxing also raised money for the blind. In 1920, the first of a long-standing series of competitions, the Stable Lads Boxing Tournament was held to raise money for St Dunstan's. Trainers held local competitions and the winners from these

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[119] *Manchester Guardian*, (May 30 1935).
[120] Kimmins, *Chailey Heritage*, (1948), p. 31.
[121] ibid, p. 82.
[122] *The Athletic News*, (Monday, July 26 1920), p. 5.

went to London to participate in the final.[124] *Sporting Life* announced that one of the races at the January Meeting at Hurst Park would be known as the Star and Garter Handicap Steeplechase.[125]

Sporting teams would give demonstrations and make charitable visits to different ex-servicemen's homes. Some Homes would stage sporting exhibitions on the premises, for instance the residents at the Star and Garter Home were given fencing, boxing and bowling exhibitions by local Richmond teams. Even casual competitions with disabled ex-servicemen were perceived as a charitable duty. In 1925, for instance, a team from the Star and Garter played billiards with the local Belmont Working Men's Club.[126] These meetings were important because it helped to re-establish some form of social normality to those war disabled. The Conservative Club had a long-running series of games with the patients.

> ...the idea of the contests was not a matter of points to their members, but a means of keeping in touch with and helping to entertain their less fortunate comrades of the war.[127]

Sometimes more famous teams would come to the home with the same charitable purpose. In 1927, for example, the Cambridge Boat Crew visited the home.[128] The debating society at the Star and Garter Home discussed

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[123] *The Athletic News*, (Monday, May 10' 1920), p. 4.
[124] *St Dunstan's Review*, Vol. 18, No. 193, (January 1934), p. 2.
[125] *Star and Garter Magazine*, Vol. 14, No. 1, (January 1934), p. 23.
[126] *Star and Garter Magazine*, Vol. 5, No. 4, (October 1925), p. 154.
[127] *Star and Garter Magazine*, Vol. 9, No. 2, (April 1929), p. 67.
[128] *Star and Garter Magazine*, Vol. 7, No. 2, (April 1927), p. 97.

sporting topics,[129] and St Dunstan's set many competitions with a sporting theme.[130]

Games and activities even formed part of disabled soldiers' visits to Buckingham Palace and other royal locations. Garden parties were held regularly by the King and Queen for wounded ex-servicemen. Part of the function of the Not Forgotten Association was to arrange for them to attend, and there was competition in the homes to see who would be chosen as the representative. Cricket, stoolball or football would be played at these parties, and for those less energetic, there was punting around the lake.[131]

Civilian disabled groups organised their own charity sporting events. While these were on a much smaller scale than that offered to the war disabled, they still assisted in making money. The Enterprise Club in Coventry raised its first £100 by way of a boxing tournament.[132] Facilities began to be provided using the goodwill of the able-bodied. The Courageous Comrades Club of Belfast, comprising students from Queens College, for example, assisted in laying hard tennis courts at a residential home for the deaf.[133]

As well as being the objects of interest for spectators, and like the majority of

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[129] such as 'football pools are desirable' and 'the present system of transfer of professional footballers should be continued'. *Star and Garter Magazine*, Vol. 19, No. 1, January 1939, p. 33. Another debate discussed whether compulsory P.T. was necessary or not. Interestingly this lost 8-1. *Star and Garter Magazine*, Vol. 19, No. 2, (April 1939), p. 31.
[130] As the favourite sport was football, many events were devised with this in mind, such as predicting which clubs would finish in the top and bottom four places in the three English divisions *St Dunstan's Review*, Vol. 16, No. 170, (December 1931), p. 8.
[131] *The Red Cross*, (October 1925).
[132] *The Enterprise Club: 50th Anniversary Brochure*, (1980), p. 5.
[133] *The British Deaf Times*, 31, No. 367-368, (July-August, 1934.), p. 89.

the population, many disabled people enjoyed watching sport. On the whole, ex-servicemen, as the more worthy had more opportunity for doing this than other disabled groups. Disabled ex-servicemen also had access to sporting events that were denied to other disabled groups, which was further evidence of their more enhanced status. Both blind and other disabled veterans obtained preferential attendance at major sporting events. Like many young men of their time, their favourite spectator sport was football. Members of both the Star and Garter Home and St Dunstan's received free admission to matches. The first time that the blind of St Dunstan's were taken to a football match was in January 1920, when a group went to the game between Chelsea and Manchester United.[134] The first time a group of disabled veterans from the Star and Garter Home attended a football match for free was in 1927 and was at the rather less glamorous Brentford football club.[135] The blind, as the most preferred disabled group were provided with better opportunities to attend sport than the less favoured amputees. By 1929 although still attending matches held at Chelsea, Fulham and Arsenal, the *St Dunstan's Review* warned their readers not to take advantage of their invitation.

> They have been more than generous in the past and we must see to it that we do not transgress upon their generosity and feel that we have a right to demand admission and create a scene if this is found impossible.[136]

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[134] Arsenal also gave free tickets to the blind in 1921. *St Dunstan's Review*, Vol. 4, No. 41, (February 1920), p. 9.
[135] *Star and Garter Magazine*, Vol. 7, No. 2, (April 1927), p. 97.
[136] *St Dunstan's Review*, Vol. 14, No. 145, (September 1929), p. 8.

Inmates were reminded that at Chelsea and Fulham, each man was only allowed one escort into the ground with them.[137] Obviously the St Dunstan's men had been trying to share their good fortune with their sighted friends. The Star and Garter Home was provided with free admission to Chelsea Football Club in 1935.[138] Football was not the only sport which disabled ex-servicemen could be admitted for free. Tickets were made available from Twickenham for rugby; and the Oval for cricket matches. Another favourite venue amongst disabled ex-servicemen were the races, where they were able to have a bet on the horses.

Although the war veterans were provided with free tickets to see the best quality football, there is no evidence to suggest that the football club's largesse extended to other disabled groups. Occasionally children in schools were taken to matches, but generally these were local games. [139] The editor of the *National Cripples Journal*, Len Inskip wrote a letter to the *Star* newspaper in 1936 suggesting that the physically disabled be admitted without charge to football matches.[140]

Disabled people did not always have to attend the event itself to enjoy able-bodied sport. Radio broadcasts provided them with entertainment. For disabled people particularly, radios meant those who had difficulty with

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[137] *St Dunstan's Review*, Vol. 15, No. 157, (October 1930), p .8.
[138] *Star and Garter Magazine*, Vol. 15, No. 1, (January 1935), p .28.
[139] Occasionally disabled children at the Wingfield-Morris Orthopaedic Centre were taken to sporting matches in their spinal carriages by hospital visitors. W.B. Foley, 'The Cripple Child', *The Journal of State Medicine*, Vol. 41, (1933), p. 724.
[140] There is no further mention of the response to the letter, so presumably it did not have the desired effect. *National Cripples Journal*, No. 30, (1936), p. 10.

mobility could be entertained at home. Besides entertaining programmes, broadcasts increasingly included radio commentary of sporting competitions.[141] Blind people were particularly keen listeners to the radio broadcasts of sport, and as the Christmas Appeal for Wireless for the Blind was inaugurated in 1930, many blind people had them by the outbreak of war.[142] The National Institute of the Blind wrote to the BBC in 1931 requesting that it did not curtail its running commentaries of sporting events.[143]

While radios were useful to blind people, television created new opportunities for deaf people. In 1937, a series of tests were carried out at the Tower House Home for Deaf and Dumb men at Erith, when GEC and the Royal Association in Aid of the Deaf and Dumb installed a television there. The *British Deaf Times* reported,

> All of them were delighted with it and they wanted to know whether they would be able to see important events, particularly football matches.[144]

Gradually civilian disabled groups began to establish themselves. Golf was a game that disabled people were able to play, in fact, one-armed golfers had

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[141] Sporting Commentaries were only commenced in 1927 when the BBC changed from a company to corporation because of restrictions on agreements with news agencies. John Ford, *This Sporting Land*, (London, 1977), p. 223.
[142] Lord Beveridge & A.F., Wells, *The Evidence for Voluntary Action*, (London, 1949), p. 220.
[143] *The New Beacon*, Vol. 15, No. 173, (May 1931), p. 108.
[144] *The British Deaf Times*, Vol. 34, No. 405-406, (September-October, 1937), p. 99.

been playing on the courses of Britain since the late nineteenth century.[145] The Association of One-Armed Golfers was officially established in 1932, and the first championship for them was held the next year.[146] In 1934 an international one-armed tournament between Scotland and England took place.[147] Prior to that inaugural match, competitions had been held at Holylake and other golf courses, which pitted one-armed golfers against each other. The most famous amputee golfer in Britain was Douglas Bader, a double leg amputee who flew fighters in the Second World War, as well as playing golf to a high standard.[148] Bader wrote, 'Golf undoubtedly is the game that a physically handicapped person can play on equal terms with others'.[149] In less documented cases, the blind were able to adapt the game of golf in order to take part. A report in *The Beacon* told of a blind officer who played golf with the aid of his caddy who rang a bell, which allowed him to aim the ball in the correct direction.[150] Another report detailed a combination of disabilities when a blind golfer used a limbless caddie when he went around a course in Newcastle.[151]

While not requiring specialised equipment, except the assistance of a sighted guide, some blind ex-officers managed to follow the hounds and continue to hunt.[152] Participation was made simpler for amputees with the development of specialised equipment, including a bridle for the single amputee and a

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[145] *Golf*, (March 25th, 1892), p. 20.
[146] *Golfer's Handbook*, (1998), p. 949.
[147] *Encyclopaedia of Golf*, (1971), p. 156.
[148] Bader's legs were amputated in 1931 following a plane crash. He began to play golf about 1934. Laddie Lucas, *Flying Colours: the Epic Story of Douglas Bader*, (London, 1953)
[149] Bader, 'I am Going to Walk', Fraser, *Conquest of Disability*, (1956), p.154-155.
[150] *The Beacon*, Vol. 4, No. 43, (July 1920), p. 14.
[151] *Newcastle Evening Chronicle*, (October 1933).
[152] *The Beacon*, Vol. 5, No. 50, (February 1921), p. 16.

saddle for those with artificial lower limbs. Unique guns were designed so that the one-armed ex-soldier could resume the sport of shooting.[153] While these aids could be seen as merely sensational, they do show that disabled people were able to make individual adaptations to games to accommodate their own particular disability.

While the disabled ex-servicemen were exposed, and in many cases actively encouraged to participate in sport, the disabled civilian adult was not provided with the same incentives, certainly before the 1940s. While events were organised for the disabled war veterans to participate in and watch, much less was done for the disabled adult. No civilian disabled, for example, were invited to attend football matches at such exalted clubs as Arsenal or Chelsea. Charity still performed an important level of support for the disabled and sport provided another means of gathering money. Charity was not only raising money, it was time spent by sporting teams or individuals at Homes or schools, passing on tips or recounting sporting glories to a group of men whose sporting lives as able-bodied people had been cut short.

The ideology of exercise and sport as a way of maintaining a healthy body and creating good character was very popular and visibly promoted in the years after the First World War. This idea filtered into schools and factories and naturally the disabled, with their physical difficulties were believed to be a group who would benefit from it. As this chapter has demonstrated children at disabled schools found that physical exercise and drill were an important part

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[153] Advertising pages in Howson, *Handbook for the Limbless*, (1922), p. 199.

of their education. There was a steady realisation that dull repetitive exercises, although clinically useful, were not good for morale or for promoting wider issues such as socialisation. The broad developments that can be observed in schools and homes for disabled children were echoed across all disabled groups. As has been argued however, there was a clear hierarchy within such developments. Blind ex-servicemen benefited most from the development of a broad programme of physical and sporting activity, and were supported by a host of institutions and charitable concerns. Developments among the civilian and industrially disabled were more ad hoc, but here still the message that exercise and sport could benefit disabled people was championed. In the inter-war years then, a physical exercise regime for disabled people was gradually developed and expanded. Organised disabled sport was still a long way off for many disabled groups prior to the Second World War, but clear foundation stones had been laid.

Chapter 3
The Disabled War: The Creation, Maintenance and Rehabilitation of Disabled People 1939-1945

While popular memory observes the First World War as a more bloody and pointless conflict than that of 1939-45, the after effects of the Second World War, with respect to disability, were more apparent. As this chapter will explain, changes in medical and other technologies dramatically increased the chances of survival for those who were wounded in conflict. This led to a growth in the numbers of disabled people, many of who would not have lived through such wounding if it had been received in 1914-18. The simple numerical facts of the situation meant that the medical establishment, the Forces, the government and society generally had to reassess how it dealt with disability.

What follows is an exploration of how disability was caused and treated in the years of the Second World War. It will argue that immediate medical discharge from the Forces was damaging to the morale of servicemen and women. Discharge from the Services upon serious injury was normally immediate, but this practice, as we will see, gradually changed. Emphasis was placed instead on keeping up morale, as part of the process of rehabilitation, and thereby increasing the serviceman's potential for a complete recovery.[1] In view of this, members of the Forces who had suffered injury were not discharged until eight

[1] CMA SA/RBC C 7.4, Service Sub-Committee of the Research Board for Correlation of Medical Science and Physical Education, *Report on the Wounded and Disabled*, Part III, March 15, 1944.

months plus fifty-six days of leave had elapsed.[2] It will come clear that the retention of injured servicemen within the Forces during their initial period of rehabilitation was central to this process, and also produced a system of dealing with disabled people that was increasingly based around military hospitals, the Ministry of Pensions and longer term care. The development of a more centralised and essentially militarised system of caring for the newly injured began under the auspices of the Emergency Medical Service, set up in 1939. This had been instituted to offer specialised treatment for the care of those who had been permanently disabled. Certain centres were established that treated specific types of injury and conditions. Hospitals and homes for disabled people that had been set up during the First World War, such as St Dunstan's and the Star and Garter continued to provide a level of care. As well as these institutions from the First World War, there were also new specialist centres, which reflected medical advances and new types of war injuries. One of the fields was burns treatment and plastic surgery. The majority of these injuries were to pilots who were shot down or crashed. The Royal Air Force had its own specialist facility in East Grinstead where Doctor Archibald McIndoe performed contemporary medical miracles on pilots with burns.[3]

Clearly wartime offered the medical fraternity new opportunities for developing treatments. As has been noted elsewhere, 'the ill winds of war have a habit to

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[2] 'Concessions to Injured Servicemen', *The Manchester Guardian*, (December 19, 1945).
[3] It was noted that 80% of those badly injured went back to flying duty and only 5% had been invalided out of the Service. PRO AIR 8/796, Memo to Sir Charles Portal from Archibald McIndoe, 1944. See also *The Lancet*, (May 6, 1944), p. 609.

blow good to surgeons and through them to surgery.'[4] During the Second World War this statement could have applied not just to surgeons, but other branches of medicine. As will be demonstrated, innovations in drug therapy, plastic surgery and rehabilitation served to minimise the effects of developments in weaponry. A major focus of this chapter will be to consider newly disabled people, those that had suffered permanent disabling effects of war. It will be shown how the treatment of disability changed, and also how the attitude towards disablement itself altered. Rehabilitation, a central theme of this study, was the most important development of the war and the most important aspect of physical medicine. But this chapter is not about those people disabled by military service only. It will also examine what happened to those civilians who were disabled on the home front and try to assess how life changed for those people who were already disabled when war broke out.

To understand the experiences of disabled people during World War Two, it is first necessary to explore how circumstances were different to those in the First World War. The Second World War saw the development and in some cases, the perfection of powerful destructive weaponry. Technological advances had improved weapons of war such as the tank, the submarine and the plane.

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[4] Leon Gillis, 'Recent Advances in the Treatment of Arm Amputations, Kineplastic Surgery and Arm Prostheses', *Annals of the Royal College of Surgeons of England*, Vol. 3, (November 1948), p. 227.

Bombs were of a larger size and when dropped from planes overhead onto cities, inflicted enormous damage, killing and maiming indiscriminately.[5] Generally civilians were the most affected by the air war when bombs were dropped on houses and factories,[6] but the loss of British aircraft was high.[7] Many pilots who survived a serious crash were badly hurt. The multiple injuries and burns that resulted from these incidents exhibited to the public a new type of war horror.

There were other aspects of the war that differed radically from that of the First World War. The frontline was more fluid than it had been between 1914-18, and moved into the towns and cities during the Blitz of 1940-41 and again in the rocket attacks of 1944-1945.[8] Since the war had come to the population's front doorstep, provision had to be made for civilians who were injured or permanently disabled.[9] As a result of such injuries there was a general feeling that benefits should be provided for those civilians injured by bombing as well as for soldiers and airmen. Indeed, in 1939 it was announced that civilian wounded would be treated as war casualties by the government.[10] By 1940, those who had lost

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[5] See P. Huskinson, *Vision Ahead*, (London, 1949) for an overall picture of bombs and the work of the RAF bomb disposal units during the War. He was blinded in an air raid in 1941.
[6] R. J. Overy, *The Air War 1939-1945*, (London, 1980), p. 208. See also Ministry of Information, *Frontline 1940-41: The Official Story of the Civil Defence of Britain*, (London, 1942).
[7] During the Blitz, more British fighters were lost to bombing on the ground than in the air. Angus Calder, *The People's War*, (London, 1992), p. 152.
[8] For details on the effects of the bombing see Calder, *The People's War*, (1992).
[9] There were 130,000 civilians killed or seriously wounded during the Second World War. Harold L. Smith, *Britain in the Second World War: A Social History*, (Manchester, 1996), p. 4.
[10] PRO CAB 117/145, War Cabinet Home Policy Committee on Rehabilitation of Disabled Persons Memo from Ernest Bevin, 13 February 1941. See also W. Franklin Mellor, (ed.), *History of the Second World War: Casualties and Medical Statistics*, (London, 1972), p. xiii.

limbs in the Blitz were being issued with a free prosthesis and spare limbs were available from 1943.[11]

While civilians were provided with better treatment for injuries suffered during the bombing, conditions at the frontline ensured that the numbers of deaths and complications were minimised. Improved transport meant that casualties could be moved to the field hospitals more quickly and with a reasonable level of comfort. When the wounded arrived at these stations, more complicated injuries could be treated in the field, increasing the chances of recovery. Unlike the First World War, field hospitals had to be moved more often; sometimes with only a few moments notice.[12] More effective methods were employed so that a serviceman could be returned to Britain with some speed if serious injury had been sustained or a long period of recovery was required. The increased use of aircraft to transport the wounded shortened the time getting back to expert care in Britain; for example, between D-Day and VE Day the Royal Air Force transported 77,348 sick and wounded service persons to Britain.[13] Transport technology had improved significantly so that the time between wound and treatment was shortened, but it was not all benefit. Many injuries were due to an increase in the numbers of servicemen who had accidents while riding motorcycles.[14] It is clear that such technological changes, while decreasing the

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[11] Gordon Phillips, *Best Foot Forward*, (Cambridge, 1990), p. 84.
[12] See Brenda McBryde, *A Nurse's War*, (London, 1980), for details of her personal experience of field hospitals during the Second World War.
[13] Theodore James, 'A History of the Medical Branch of the Royal Air Force: Part 2', *Adler Museum Bulletin*, Vol. 10, No. 2, (1984), p. 6.
[14] It was estimated that 65,000 servicemen were admitted for traffic accidents not due to operations of war. 23,000 of these were aboard motorcycles. Eileen M. Brooke, 'Emergency

number of deaths, vastly increased the numbers of disabled that would enter society.

The mechanisation of war with its increased ability to cause widespread damage to buildings and bodies was matched by the ingenuity of discoveries. This was particularly evident and fortuitous in the field of medicine. The drugs and techniques developed meant that people who would have previously died, survived serious injury. It is generally accepted that there were three advances in medicine that affected the death rate during the war, and war was responsible for their accelerated development.[15] Two of these innovations were advances in new drugs and the third was the widespread use of a particular technique. Both of the new drugs had been developed before the war, but like other discoveries at that time their use became more widespread as a result of the conflict. In 1935 sulphanilamide was discovered.[16] The strength of this new substance was that it could control widespread infection in the body. In war this was especially important, as secondary infection following injury was the cause of many deaths. The ability of the sulpha drugs, as they were named, to wipe out infection also made them a powerful weapon against secondary infection which previously had caused many deaths.

Medical Service' in W. Franklin- Mellor (ed.), *History of the Second World War: Casualties and Medical Statistics*, (London, 1972), p. 793.
[15] Frederick Cartwright, *A Social History of Medicine*, (London, 1977), p. 169.
[16] Anne Hardy, *Health and Medicine in Britain Since 1860*, (Basingstoke, 2001), p. 104.

In addition to the sulpha drugs, penicillin had also been the subject of pre-war research. Although the French had experimented with it in the late 1920s, and Fleming had accidentally grown some in1928, there was still no way to purify it.[17] Florey and Chain developed Fleming's work in Oxford in 1939,[18] and it was not until after the war had been under way about two years that it became more easily available. A crude variety of the drug was manufactured in small quantities in 1941, with increasing capacity by 1943.[19] The strength of penicillin was that it could control localised infection, and was useful in certain types of medical condition, including sexually transmitted diseases. In the case of more serious injury, amputation became less likely with penicillin available, as the danger of gas gangrene was reduced. The only problem with penicillin was that it was not available in large quantities, so only the servicemen fighting on the front lines were given the drug.[20] Since the effects of penicillin on infection were so great, every effort was made by the military authorities to produce sufficient quantities.[21] At crucial stages of the war, penicillin was credited with having a significant impact on recovery rates, for example during the D-Day landings in Normandy in 1944, the Army had an organised agenda for the administration of penicillin. The 21st Army Group's programme ensured that most of the wounded had a penicillin

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[17] For Accounts of Fleming's work see Ronald Hare, *The Birth of Penicillin and the Disarming of Microbes*, (London, 1970).
[18] John Ellis, *The Sharp End: The Fighting Man in World War II*, (London, 1990), p. 170.
[19] Cartwright, *A Social History of Medicine*, (1977), p. 148.
[20] Anne Hardy, *Health and Medicine in Britain Since 1860*, (Hampshire, 2001), p. 136.
[21] In his article on the trails of penicillin in the Second World War, Peter Neushul argues that military intervention with medicine ensured that the development of penicillin from its experimental stages to a mass produced drug was shortened in an unprecedented way. Peter Neushul, 'Fighting Research: Army Participation in the Clinical Testing and Mass Production of Penicillin During the Second World War', Cooter et al, *War, Medicine and Modernity*, (Stroud, 1998).

injection within a few hours of their injury.[22] Penicillin and its rapid administration was one of the reasons given why the number of those surviving but disabled at the latter stages of the war.[23]

As well as new drugs that fought infection, certain innovations were made which also improved servicemen's chances of recovery. The technique that was perfected and also had an enormous impact during the Second World War was blood transfusion. The introduction of blood and plasma to a casualty lessened the body's shock reaction, and again limited mortality. However, this technique was not new, and had been used on a limited scale during the First World War. The major problem with this technique in the past had been the scale and location of provision, as blood had to be transfused directly from one patient to another, since there was no knowledge of how it could be stored, and it was impossible always to have a group of donors present when blood was required. This problem was solved during the Second World War when it became possible to refrigerate blood and plasma,[24] which meant that there were usually supplies on hand. Britain had a central blood bank prior to the war with 5,000 donors, which increased to 350,000 by 1944.[25] It was noted that, 'Supplies were so

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[22] Ellis, *The Sharp End*, (1990), p. 170.
[23] Those who survived with a disability during the Second World War immediately following the Normandy landing was 14%, whereas in World War One it was 8%. Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 445.
[24] Douglas Guthrie, *A History of Medicine*, (London, 1945), p. 350.
[25] Whitby, 'The Transfusion of Blood and Other Fluids', Zachary Cope (ed.) *History of the Second World War: Surgery*, (London, 1953), p. 47.

abundant that at one phase of the war a wounded man was almost lucky if he escaped a transfusion'.[26]

While these innovations in drugs and medical techniques saved lives, there is little doubt that as many wounded servicemen survived extensive injury, there were other considerations that had to be made in regard to their recovery and any residual disability as a result. Other medical improvements that owed more to therapy than to drugs also advanced during the war and had an impact on those unable to recover fully.

One of these new treatments that would impact on the wounded servicemen was physiotherapy. The growth of physiotherapy, as an active as opposed to a passive treatment in the 1920s and 1930s and its expansion during the Second World War had lasting implications for many disabled people. In 1938 a Massage Corps was established in preparation for hostilities.[27] Although the establishment of a Massage Corps showed that physiotherapy was gaining in respectability, medical practitioners were still not completely convinced. Even in 1939, the medical profession had not been certain of the value of physiotherapy, the *British Medical Journal* suggesting that in fracture cases, occupational therapy was 'even more important'.[28] Despite the BMA's scepticism, by 1942 there were 6,000

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[26] Whitby, 'The Transfusion of Blood and Other Fluids', Cope (ed.) *History of the Second World War: Surgery*, (1953), p. 50.
[27] The Corps was mainly staffed with volunteers, in 1938 there were 1500. Jane Wicksteed, *Growth of a Profession*, (London, 1948), p. 132.
[28] *British Medical Journal*, (August 19, 1939), p. 419.

members of the Massage Corps working in different fields and various locations around the world.[29] Methods were becoming more scientific and their benefits clearer to the medical profession. Even the name changed in 1943 when the Massage Corps became the Physiotherapy Service. The war interfered with some of the treatments, for instance short wave therapy and diathermy had to be stopped as they interfered with aircraft radio waves, but physiotherapy became an important part of the rebuilding of those who were injured by war.

Medical technologies also were advanced by the war, including improvements in the treatment of burns and the development and provision of artificial limbs. Through the sheer weight of numbers of injured pilots, plastic surgeon and burns specialist Archibald McIndoe was able to improve his technique and provide some relief from permanent disfigurement.[30] Innovations in techniques and materials in the fitting and production of artificial limbs were also developed. Cineplasty, for example, an operation where the muscles of the remaining stump were used to assist in the activation of prosthesis, was gaining medical interest.[31] Like physiotherapy and drug developments, these specific therapies advanced more rapidly due both to the necessity of recovery and the greater numbers of permanently disabled people with which the medical profession had to deal.

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[29] Jean Barclay, *In Good Hands*, (Oxford, 1994), p. 125.
[30] McIndoe's patients wrote about their experiences, and were also the subjects of books about the Guinea Pig Club, a group formed during the war, comprised solely of burned airmen. For personal testimonies see Richard Hillary, *The Last Enemy*, (London, 1961), William Simpson, *The Way of Recovery* (London, 1944), and Peter Williams and Ted Harrison, *McIndoe's Army*, (London, 1981).

While advances in medical science served to promote recovery from serious wounds, and a more full recovery was possible through physiotherapy and aids such as artificial limbs, there arose the problem of what to do with these injured servicemen, some of who would have serious residual disabilities. One of the single most important developments of physical medicine during the war was rehabilitation. It was the word on the lips of both health professionals and government legislators in the latter stages of the Second World War and the immediate post-war years. In 1941, '...rehabilitation became the most fashionable word in medicine...'[32]. As the nature of its application widened, increasingly diverse terms of reference developed around the word rehabilitation; 'resettlement', 'habilitation' or 'reablement'[33] all referred to the process of become fit again after damage. But what was rehabilitation?

> In its strictly medical sense (rehabilitation) means the process of preventing or restoring the loss of muscle tone, restoring the full fluctions of the limbs, and maintaining the patient's general health and strength.[34]

Ostensibly, the foremost purpose of rehabilitation was to restore the same level of health that the injured person had enjoyed prior to their illness or injury. But

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[31] This operation was performed far more extensively in the United States than in Britain. Henry H. Kessler, *Cineplasty*, (Illinois, 1947), p. ix & 51.
[32] Richard M. Titmuss, *Problems of Social Policy*, (London, 1950), p. 478.
[33] For a discussion on terms, see *British Medical Journal*, (March 24, 1941), p. 793.
[34] PRO, CAB 117/145, *Tomlinson Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1941-1943.

physical health was not considered to be the only type of health that was important.

> The importance of the morale factor cannot be over-stressed. It is essential to remove the inertia and despondency of hospitalisation and to restore this "will to get well"'[35]

Rehabilitation took many forms, as we will see later in this chapter, and was endorsed by the State. During the war, government committees were formed which attempted to come to grips with the problems of mass disability brought about by war. The most influential report of the war that affected disabled people was the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons, headed by George Tomlinson, which reviewed the field of rehabilitation. The report was published in 1942 and was presented to Parliament in 1943.[36] Its recommendations included the extension of rehabilitation services for all patients and by 1945, the hospitals that provided rehabilitation facilities had doubled.[37] Richard Titmuss noted that,

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[35] CMA SA/RBC C7.4, Service Sub-Committee of the Research Board for Correlation of Medical Science and Physical Education, 'Report on Wounded and Disabled, Part III', March 15, 1944.
[36] PRO CAB 117/145, *Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, January 1943.
[37] *The Lancet*, (February 10,1945), p. 196.

> The creation of a framework for a national rehabilitation scheme may thus be recorded as one of the chief successes of the Government's Emergency Medical Service.[38]

There needed to be an effective form of treatment to return the many injured of the war back to health. Due to the emphasis in medical journals, such as *The Lancet*, the *British Medical Journal*, government reports and newspapers such as *The Times*, it would appear that rehabilitation was the newest development of the 1940s, but this was perhaps an exaggeration. As we have seen earlier, rehabilitation by another name had been practised throughout the early part of the twentieth century. When orthopaedic surgeons such as Sir Robert Jones had treated the wounded soldiers of the First World War, his practise provided an important basis for the contemporary rehabilitation model.[39] Credit was given to those early pioneers of what became known as rehabilitation in an article in the *British Medical Journal* of 1942.

> Rehabilitation is not a new method of treatment at all. It is the application to all types of recent disability of those varied methods of supervised exercise which exponents of physical medicine have advocated for years.[40]

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[38] Titmuss, *Problems of Social Policy*, (1950), p. 480.
[39] *The Lancet*, (July 29, 1944), p. 131. For work on early rehabilitation methods, particularly those of Robert Jones, see S. Alan and S. Malkin, 'The Conquest of Disability', *Annals of the Royal College of Surgeons*, Vol. 20, (1957), Watson, *Civilisation and the Cripple*, (1930), and Anderson, *A Record of Fifty Year's Service to the Disabled 1919-1969*, (1969).
[40] *British Medical Journal*, (October 17, 1942), p.466.

The difference during the Second World War was in the scale of its use and its wider application to injuries and disabilities. Prior to the outbreak of the Second World War, centres for rehabilitation were small and were only used successfully in cases of particular types of disablement, like fractures. It became popular because its successful application meant that those injured would recover more quickly and could return to the war effort sooner. Only certain types of injury were treated and the benefits were limited to a relatively small number of patients. These basic methods improved and became more sophisticated as the War progressed and by 1945, over 250 hospitals in England and Wales had adopted rehabilitation methods, 'including physiotherapy, remedial exercises and handicraft',[41] and specialist rehabilitation units increased from 35 in 1943 to 121 in 1946.[42] The growth in rehabilitation centres not only reflected the number of injured, but also the types of wounds and the increased survival rate. The British Council for Rehabilitation was formed in 1945, its remit to co-ordinate the whole process, to gain the co-operation of government departments to promote its study and practise, and to obtain assistance from private organisations to help with resettlement.[43] Although the time frame for the start of rehabilitation differed slightly, all methods were designed to restore the working capacity of the

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[41] *The Lancet*, (February 10, 1945), p. 196.
[42] Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1946.
[43] *The Lancet*, (March 3, 1945), p.2 85.

disabled person, either partly or fully.[44]

> But there is a determination in the Government to create the opportunity for employment of the disabled, not because the country is in peril but because the disabled are capable and worthy of employment.[45]

For those with a serious disability that prevented them from finding work in the mainstream, special institutions were established, including the originally named British Factories, which were later renamed Remploy.[46]

Although physical recovery of the individual was the main aim and most desired result of rehabilitation, there were other factors that impinged on its enthusiastic adoption by the State. Was the restoration of health to the individual the most important task of rehabilitation? As well as a return to the best possible health as possible, notwithstanding residual disability, fundamental consideration was also given to the injured person's economic capacity as a worker or as part of the war effort. The government considered the return of the disabled to a 'normal' life a 'national duty'.[47] Whilst this was laudable and also an obvious commitment to the war wounded, there were other factors that contributed to the governments eager adoption of methods of rehabilitation.

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[44] *The Lancet*, (April 15, 1944), p. 521.
[45] *The Lancet*, (March 31, 1945), p. 411.
[46] Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1946.
[47] PRO CAB 117/145, *Tomlinson Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1943.

...a disabled person represents a double loss to the community, vis. A reduction of the total productive capacity and an increase in the cost of maintenance and remedial services, the restoration of the disabled person to productive employment will be an economic advantage.[48]

Other writers stressed the advantages to Britain of the individual's rehabilitation and return to work.

> And it must not be forgotten that not only the injured man and his family, but also the nation as a whole suffers economically from a man's inability to work. Both in wartime and in the period of post-war reconstruction, this factor is of vital importance to Britain.[49]

As we noted earlier, a serious side effect of disablement was depression and it was important that this condition be lessened, as it would interfere with recovery and possibly more importantly, productivity. How did rehabilitation work on a practical level? Although treatment varied according to the type of injury sustained, a similar method was adopted by most hospitals when a patient was admitted. As soon as possible, the patient would be busied with occupational therapy; two examples of bedridden types were basket making and rug weaving. The other important aspect of rehabilitation was exercise. Many patients were

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[48] Ibid.
[49] Harold Balme, *The Unfit Made Fit: Britain Advances*, (London, 1943), p. 9.

given remedial exercises to perform while still in bed and they were also given different types of physiotherapy, consisting of repetitive exercises usually assisted with strings and pulleys, refined from the earlier designs of the First World War. As mentioned previously, the use of physiotherapy was becoming wider, and with it the more active types of treatment. According to Olive Guthrie-Smith, the developer of the apparatus that bears her name,[50] 'Suspension exercises are varied and interesting to perform owing to the rhythm and freedom of movement...'[51] Other contemporary physiotherapists agreed that '...weightless exercise is almost as good as a swimming pool... with the added advantage that it is dry so a chill can be avoided'.[52]

Unfortunately those having to perform these remedial exercises did not always agree that they were 'varied and interesting', They were considered boring and repetitive, but still a necessary part of therapy. As we have seen, games had provided entertainment for men in institutions such as the Star and Garter and St Dunstan's after the First World War, and these activities began to be more formalised as part of the rehabilitation regime, while also being given more importance in the overall recovery of the wounded serviceman. Many centres established by the Services used sport as a means toward rehabilitation, as it

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[50] Both the apparatus and its name underwent many changes and improvements. The apparatus was originally call 'Slings and Pulleys', then 'Treatment by Suspension' and finally the 'Guthrie-Smith Apparatus', in *St Mary's Hospital School of Physiotherapy (Swedish Institute) Magazine*, (1954), p. 8.
[51] Olive F. Guthrie-Smith, 'Rehabilitation Exercises', *The Journal of Massage and Medical Gymnastics*, (October, 1940), p. 3.
[52] Lanckenau, 'Rehabilitation by Modern Methods of Exercise', in Doherty and Runes, (eds.), *Rehabilitation of the War Injured*, (1945), p. 618.

was considered to be fun and it was felt that as enjoyable recreation, it would help to keep up the spirit of those in the treatment centres, while occupying their time. Although the medical profession considered remedial exercises and physiotherapy more important aspects of the rehabilitative process, sport was imbued with other benefits that included the psychological. It was also felt that sport would re-create the sense of ordinary human association, especially in the case of those who had been permanently disabled.[53] Recreational games became important, for both the health and the mental well being of those recovering from wounds.

While exercise and games were an important part of service life and also part of their rehabilitation programme, each individual Service had a different way of dealing with their injured. Each branch operated its individual rehabilitation centre in keeping with its own agenda. Although rehabilitation centres were different in scope to a certain point, all of them had one component in common: the desire to return the soldier, sailor or airman to the war effort as quickly as possible. For those who had suffered permanent disability, it was felt that rehabilitation would lessen that disability or at the very least curb the residual impact.[54] The Royal Air Force was credited with having the best rehabilitation service, although criticism was made of the policy of retaining patients for a prolonged period of time and the large number of beds in its rehabilitation

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[53] Hobson, *Physiotherapy in Paraplegia*, (1956), p. 77.
[54] Reginald Watson Jones, 'Rehabilitation in the Royal Air-Force', in Doherty and Runes (eds.) *Rehabilitation of the War Injured: A Symposium*, (1945), p. 439.

centres.[55] Like all service jobs, flying had its share of risks. Due to the high altitude maintained by the bombers, many aircrew lost fingers and toes to frostbite and suffered ear problems due to the lack of pressurised cabins. Crash injuries could involve trauma and possible paraplegia from the violent movement of the spine in a sitting position as well as burns. The regime in the rehabilitation centres was relentless, but the RAF needed to repair its men and of all the services it had the highest rate of returning to duty rehabilitated men, some with substantial residual disablement.[56] In total, there were 73,868 'invalidings' from the RAF, but only 1,140 were due to injury, which caused permanent disablement.[57] One of the reasons for the success of the RAF rehabilitation campaign was the belief that, 'Rehabilitation does not begin with recreation and games; it begins with work and very hard work'.[58]

While games and other activities including occupational therapy, which had previously been viewed as vital for recovery, were not considered beneficial to the recovering airmen, exercise certainly was. Tough militaristic values pervaded when a serviceman was recovering from injury. Some RAF patients worked in

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[55] S.C. Rexford Welch, 'Royal Air Force' in Franklin Mellor (ed.), *History of the Second World War: Casualties and Medical Statistics,* (1972), p. 469.
[56] One of the most famous of these severely disabled men was Douglas Bader, who flew fighter aircraft despite being a double leg amputee. There were other double leg amputees in the Air Force, including Colin Hodgkinson whose book *Best Foot Forward* (London, 1957) details his experiences. 85% of severely injured air crew resumed a flying category or operational duties. *The Lancet*, (May 6, 1944), p. 609.
[57] The remainder of those discharged from the Service was due to nervous disorders (24,807), TB (6,362) or disease (41,559). Rexford Welch, 'Royal Air Force' W. Franklin Mellor (ed.), *History of the Second World War: Casualties and Medical Statistics*, (London, 1972), p. 595.
[58] Watson Jones, 'Rehabilitation in the Royal Air-Force', in Doherty and Runes (eds.) *Rehabilitation of the War Injured: A Symposium*, (London, 1945), p. 428.

the gymnasium, performing remedial exercises for the whole day, not even leaving the gym for refreshments as a milk bar was installed there.[59]

> It is considered that more improvement is made in the early stages of treatment by encouraging the patient to concentrate on overcoming his disability by working away at it all day long.[60]

While relentless muscle building exercises were encouraged, the more passive forms of physiotherapy were not.

> because some patients are only too happy to lie at their ease on a couch and receive treatment which, for remedial purposes, is a poor substitute for their own activities.[61]

After a programme of exercises, sport and games were introduced in the last phase of rehabilitation. For those recovering in the orthopaedic rehabilitation centres, for example, remedial exercises were the first phase of rehabilitation, followed by a second set of activities including, swimming and remedial exercises of increased difficulty, rounded off by a return to sports such as golf, tennis and

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[59] There is no location given for this RAF hospital. R.N. Houlding, 'Rehabilitation of Injured Air Crews in Great Britain' in Doherty and Runes (eds.), *Rehabilitation of the War Injured: A Symposium*, (1945), p. 442.
[60] Houlding, 'Rehabilitation of Injured Air Crews in Great Britain', in Doherty and Runes (eds.), *Rehabilitation of the War Injured: A Symposium*, (1945), p. 443.
[61] Ibid, p. 445.

volleyball.[62] So while exercises to rebuild lost muscle were important for recovery in the RAF, reward was provided for all that hard work in the form of games and sport. It is evident that sport was important for the RAF as some of their rehabilitation centres were housed where the injured could have access to facilities, for example, in 1942 the RAF took over Loughborough College as a rehabilitation centre partly because it still had good playing fields.[63] The Palace Hotel in Torquay, Devon was reopened as an Officers Hospital, where facilities included a putting course, swimming pool, squash and indoor tennis courts and a gymnasium.[64]

While the RAF had a very centralised rehabilitation system, other Services did not. The Navy had its own hospital centres, but it usually discharged most of its severely wounded to civilian hospitals. Eventually the Navy would have its own rehabilitation centres but they were not opened until 1944. [65] Before that both naval and army patients were transferred to EMS hospitals, 'until a high proportion of military patients in the United Kingdom were in civil hospitals.'[66] The Army however, relied heavily on the civilian resources of the EMS for the treatment and rehabilitation of its men. It ensured that discipline would be maintained by placing its own physical training instructors into the rehabilitation

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[62] Houlding, 'Rehabilitation of Injured Air Crews in Great Britain', in Doherty and Runes (eds.), *Rehabilitation of the War Injured: A Symposium*, (1943), p. 442.
[63] S.C. Rexford Welch, *The RAF Medical Services*, Vol. 1, (London, 1954), p. 314.
[64] Ibid, p. 315.
[65] CMA SA/RBC C7.5 Letter to Miss Lloyd-Williams, Secretary Research Board, Ling Association from K Digby-Bell, Surgeon Captain of the Medical Department of the Royal Navy, 14th January 1944.
[66] Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 100.

units, some of which were operated by the EMS, others run by the Convalescent Department.[67] With the establishment of the Emergency Medical Service in 1937 the lines between the Services Hospitals and the civilian ones had become blurred, and as the war progressed, EMS hospitals adopted the Services method of keeping records on the patients.

While the majority of Service patients in rehabilitation centres were men, more women participated in the war effort than had been the case in 1914-18, and required treatment for injury. Rehabilitation provision for women was still at a very early stage of development as outlined in a report by the Auxiliary Territorial Service on *The Wounded and Disabled*.

> Rehabilitation in the ATS is still in an experimental stage...because experience in the rehabilitation of women in other walks of life is almost non-existent and policy, method and training have to be worked out from scratch.[68]

The difference between rehabilitation for men and for women was demonstrated within the same report. Whereas the common perception was that men enjoyed rehabilitation which was derived from exercise and hard work, the same could

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[67] CMA SA/RBC C.7.5, 'Report on the Wounded and Disabled, Part III, Services Sub-Committee of the Research Board for the Correlation of Medical Science and Physical Education', March 15, 1944.
[68]CMA SA/RBC C.7/5 ATS Report, 'The Wounded and Disabled', (undated, presumably 1944).

not be said for women, who were perceived generally as lazy and had to be cajoled into activity, as the authors of the report complained.

> ...In its [physical exercise] absence, [women patients] tend to sit about over the fire or on the lawns and on their return to their units are found to be unfit for a full days work.[69]

Although rehabilitation was vital for those who had been injured, many more women in the Women's Auxiliary Air Force were discharged from the Service due to disease and illness, which included mental disorders, than were made permanently disabled through injury.[70] Figures from the ATS show that the numbers of injuries from enemy action were only responsible for two percent of total numbers in the Services.[71] However the wounded accounted for half of the total of casualties suffered by the Women's Auxiliary Services.[72]

The theories that lay behind the use of rehabilitation were also used as part of the campaign of preventative measures. As we saw in Chapter Two, physical development depots were opened between the wars, but closed down when war was declared in 1939. They were reopened by the War Office when those conscripted under the National Service Acts were found to be in relatively poor

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[69] CMA SA/RBC C.7.5, ATS Report, 'The Wounded and Disabled', (undated presumably 1944).
[70] Only 65 women were discharged from the WAAF due to injury. Rexford Welch, 'Royal Air Force' Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 632.
[71] Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 446.
[72] Central Statistical Office, *Fighting with Figures*, (London, 1995), p. 43.

physical shape, despite the more concerted efforts of the national fitness campaign of the thirties.[73] The first centre was re-opened in 1941, and in two years 12, 000 men had received a course of eight weeks duration. This consisted of remedial training and physiotherapy, as well as drill, games and recreation.[74] Most of those who attended these Centres were conscripts with early scoliosis, poor posture and flat feet. A few young officers who had been wounded in the fighting and were in need of 'restoration' were also included in the regime at the Physical Development Centres.[75] This standard was also applied to women who were conscripted. Women who enlisted in the ATS were also sent to reconditioning centres to have their 'postural or foot defects' cured and generally raised to a higher standard of physical fitness.[76]

For those suffering more permanent disability in the Forces, being 'invalided out' was the only option. Whilst in the Forces, a patients rehabilitation was the responsibility of their own particular Service, but should their disability be permanent, they were discharged. Although a few stayed in the services after serious injury, the majority of servicemen and women were invalided out on 'medical grounds'. Figures for the Army differed widely from year to year. For instance in 1943, 46% of total discharges were a result of enemy action, whereas

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[73] PRO CAB 117/145, *Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1943.
[74] CMA SA/RBC C7.4, Services Sub-Committee, 'The Sub-standard Recruit', (undated, but the Services Sub-Committee first met in December 1943).
[75] Ibid.
[76] Ibid.

in 1945 it had risen to 75%.[77] Apart from enemy action, or injury as a result of being in a war zone, though not directly attributable to the fighting, servicemen were discharged for a multitude of reasons. Mental disorders or shell shock, as it was commonly known in the First World War, still accounted for 50% of all discharges on medical grounds other than physical injury.[78] Also stress induced were the high number of stomach ulcers which led to early discharge. Once a recruit was discharged as being too severely disabled, each Service relinquished responsibility for rehabilitation. All of the Services used the employment retraining provided by the Ministry of Pensions or the Ministry of Labour and National Service. It was believed that despite serious injury or merely not being up to the rigours of fighting that the discharged serviceman could still serve his country in industry or some other facet of the war effort. How easily an ex-serviceman could move back into civilian employment was an important consideration. The level of 'degree of disablement' was an important indicator of how easily this could be accomplished. If the degree of residual disability was judged to be 40% or less, then the Army deemed that the ex-servicemen would have access to a more abundant choice of employment than would another who had a higher disability percentage.

Though unable to serve on the front lines, discharged ex-servicemen were still capable of helping the war effort in other ways. It was essential to hasten the

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[77] Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 444.
[78] Franklin Mellor, *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 439.

return of the disabled back to the factory, the mine or the fighting. It is evident that the government showed a keen interest in restoration of some level of fitness, as the Ministry of Labour and National Service controlled many of the civilian rehabilitation centres that were opened both during and after the war.[79] These disabled ex-servicemen were often sent for re-training at Centres such as Egham, which opened in 1941[80] or Roffey Park[81], where they gained the skills for other types of war work.

> The object of the Centre is to restore confidence and mental and physical fitness through healthy indoor and outdoor occupation, and physical exercises.[82]

The majority of the disabled men who attended these training centres were unable to return to their former occupation, but were trained for alternative types of employment. While many disabled people were retrained at Egham, certain disabilities were exempt from attending, including blind people[83], any person with TB or another contagious disease and epileptics.[84] Women were also not allowed to attend any of the rehabilitation centres, unless they were specifically

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[79] The Egham Centre in Kent was one of the largest government run rehabilitation centres. *The Lancet*, (April 29, 1944), p. 596.
[80] PRO FD 1/6809 Ministry of Labour and National Service Pamphlet 'Egham Centre' PL 137/1943, October 1943.
[81] PRO FD 1/6809 Ministry of Labour and National Service Pamphlet 'Roffey Park, Horsham', undated, presumably 1943.
[82] PRO FD 1/6809, Pamphlet from Egham Centre in Surrey, Ministry of Labour and National Service (PL 137/1943), October 1943.
[83] The blind were trained at specific jobs such as masseuse and telephone operator at centres exclusive to them, such as the Royal Normal College.
[84] PRO, FD 1/6809, Ministry of Health Circular 2863, 30 October, 1943.

designed for them. It seems clear that one of the main reasons for the rapid and large-scale adoption of rehabilitation during and after the Second World War was that manpower was at such a premium.[85]

The division between those perceived as the more worthy war disabled and the less important civilian disabled, which was established in earlier chapters, was still evident, despite the establishment of centres such as Egham. The report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons still applied mainly to those injured in the war or as a result of enemy action. As victims of bombing, those civilians became a type of war wounded, therefore joining the ranks of ex-service personnel who received a different standard of treatment and assistance. Other disabled civilians, and those people made disabled as a result of injury while employed in industry, were largely ignored, although the report did mention that the industrial disabled were to have been assisted under the hospital schemes, which had been recommended by the Delevingne Committee's in 1939.[86] Ernest Bevin, Minister of Labour and National Service wanted rehabilitation to apply to others besides those in the Services, particularly those made disabled while working in industry.

> Both Committees were of the opinion that the Government's responsibility in respect of the Civil Defence Services and civilians who suffer injury

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[85] Cooter, *Surgery and Society in Peace and War*, (1993), p. 199.
[86] The report made a possible exception for miners. PRO CAB 117/145, *Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, January 1943.

> through enemy action should be as complete as that in respect of ex-service casualties, but I take the view that casualties in industry should be treated on exactly that same basis.[87]

Bevin obviously had little time for the preferential system that still existed for disabled ex-servicemen, and wanted to see industrial workers awarded the same treatment as the war disabled.[88] Bevin was right to be concerned about the industrial disabled as the numbers of accidents in factories was increasing.[89] He showed his commitment to those injured in industry as he established special rehabilitation centres for the industrial disabled. In 1942, for example, the Claremont Hotel in Manchester was opened to house a rehabilitation centre for disabled dock workers.[90] But, there were very few of these centres specifically for the industrial disabled as prior to the establishment of the National Health Service in 1948, most centres for rehabilitation were controlled either by the private companies who provided employment, or by occupational group.[91] The Miners Rehabilitation Centres and hospitals, for example, were controlled under the auspices of the Miners Welfare Commission. As the war progressed, the

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[87] The Committees Bevin referred to were investigations into rehabilitation of disabled persons headed by Sir Edward Forber for the Ministry of Health and another under J.M. Glen for the Ministry of Labour and National Service. PRO CAB 117/145, Memo from Ernest Bevin, War Cabinet Home Policy Committee on Rehabilitation of Disabled Persons, 13th February 1942.

[88] For a discussion on labour and the Services see David Englander, 'Soldiers and Social Reform', *Historical Research*, Vol. LXVIII, No. 164, (1994).

[89] In the Annual report of the Chief Inspector of Factories the increase in the number of accidents on the previous year, 1939, were 33% in engineering works, 47% in the making of machines and 21% in chemicals. There was an increase in the number of explosions, not only in munitions factories, but also in flour mills and cattle feed factories. CMA SA/RBC C8.9, Annual Report of the Chief Inspector of Factories, Cmd 6316, 1940.

[90] PRO LAB 20/1Memo from R.P. Williamson Ministry of War Transport to S.G. Holloway Ministry of Labour and National Service, 13 June 1945.

government, through its different departments, set up special units to deal with particular industries. The Ministry of Supply established rehabilitation units in Ordnance factories in order to treat those injured during work in the extremely hazardous munitions industry.[92] The recognition of the worker in industry as part of the war effort was probably the key to the establishment of these rehabilitation centres.

While war created a new generation of disabled people, what happened to those who were already disabled? Just prior to the war, unemployment rates were very high especially in the north east of England, central Scotland and south Wales.[93] With the onset of war, the demand for labour in the munitions industries increased dramatically. Neither employing large numbers of women nor redeploying the retired could quench this thirst. Disabled people became worthy citizens. The wounded of the First World War who had been criticised for begging in the street were suddenly valued workers. In October 1941, the Ministry of Labour announced an 'Interim Scheme for the Training and Settlement of Disabled Persons in Industry'.[94] The government required disabled people to work in particular jobs especially in munitions factories.[95] As well as this scheme, an inter-departmental committee was established to make

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[91] PRO FD 1/6810 Report by H Balme for the Ministry of Health, 'Rehabilitation in the New Health Services', 1945.
[92] PRO FD 1/6810, Balme, 'Rehabilitation in the New Health Services' 1945.
[93] Calder, *The People's War*, (1997), p.
[94] Titmuss, *Problems of Social Policy*, (1950), p. 478.
[95] According to their official history, the Infantile Paralysis Fellowship assisted in helping the government form policy, when a member of the association wrote to Ernest Bevin with details on how those with polio could help in the war effort. Barry North, *Something to Lean On*, (1999), p. 6.

proposals for a more permanent system to train and employ the disabled after the war.[96] As the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons noted,

> The real position is obscured by the prevailing shortage of labour and the ease with which disabled persons (including many who are below the normal standard of fitness) can obtain employment for which in normal times a higher standard of fitness would be required.[97]

As a result of the war and the resultant labour shortage, disabled people were provided with the chance to do jobs for which they had been thought unqualified. Unlike women, disabled people were never conscripted, but filled jobs recently occupied by the able-bodied who were needed for other work. Hilda Baines, for example had been born deaf and was passed as fit and went to work in an ordnance factory. As she said later, 'I didn't think they'd pass me fit...they passed anyone in the war.'[98] In some cases, disablement was actually regarded as an asset in the workplace. Apparently the noise level caused during certain stages in the construction of a shell could damage the hearing of those with a normal range, and due to the lack of safety equipment it was understood that deaf people were best placed to perform this job.[99] Baines worked in assembly where

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[96] W.L. Buxton, 'Industrial Rehabilitation Units', *International Labour Review*, Vol. 67, (1953), p. 535.
[97] PRO CAB 117/145, Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons, January 1943.
[98] IWM Sound Archive, 12481/2, Interview with Hilda Baines, April 5th, 1992.
[99] 'Where Only Deaf are Employed', *The British Deaf Times*, Vol. XXXVII, No. 433-434, (Jan/Feb 1940) .p.9.

she was the victim of another accident when a bomb with a faulty gauge exploded in her hands causing her to lose most of both of them. Yet she went back to work in the same factory after a year off. Though she could not work at the same job as before, she did a range of jobs there for another seventeen years.[100] Many deaf people went to work in industry. Generally this was seen in a very positive light and stories were circulated of how important the deaf's war work was, and their effort and dedication was praised in industrial dispatches. The *Birmingham Post* printed a humorous story about a deaf girl who also had polio and was placed in a factory: 'They put the deaf girl between two of the most talkative employees, and output has considerably increased'.[101]

Blind people also clamoured for war work. At the National League of the Blind Conference in July 1940, blind people passed resolutions pressing the Government to give them work of 'national importance'.[102] By 1942, the Ministry of Labour had authorised the employment exchanges to give priority and look upon blind people 'favourably' when they made applications to work in industry.[103]

As well as this official scheme for employing the disabled, a more casual system was also in place, where those with disabilities filled the jobs of those in hospitals

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[100] IWM Sound Archive, 12841/2 Interview with Hilda Baines, April 5th, 1992.
[101] *Birmingham Post*, (April 6th 1942).
[102] *The New Beacon*, (August 15, 1940), p. 158.
[103] By 1945, 2,000 blind were engaged in industry, Michael W. Royden, *Pioneers and Perseverance*, (Liverpool, 1991), p. 210.

and farms.[104] This scheme provided jobs for between 300,000 and 500,000 disabled people during the war.[105]

Disabled women joined the Auxiliary Forces such as the Women's Land Army. Journals for deaf people reported proudly on the exploits of these women.[106] Being disabled was not a bar to being employed in the Auxiliary Territorial Services. Iris Hobby was given Grade A fitness to work with the Women's Land Army on a dairy farm, although she could only bend her knee halfway as a result of bovine tuberculosis.[107] Other disabled people were able to take up clerical work for which there were no physical barriers. In 1940, Emily Porter, who also suffered from bovine tuberculosis of the spine, applied for and got a clerical job censoring mail. After the war she progressed into a permanent job as a civil servant.[108] The war helped many disabled people into jobs and moved them away permanently from a life of unemployment and poverty.

Disabled people unable to get paid employment, or those working who wanted to do more to assist the war effort, could help on the home front. Many of them participated willingly in the 'Dig for Victory' campaign, and journals for the blind and deaf were full of instructions for setting up an allotment and what food to

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[104] Humphries and Gordon, *Out of Sight*, (1992), p. 129.
[105] There is some disagreement on this point. *Western Daily Press*, 22.2.43, as cited in Calder, *The People's War*, (1997), p. 387 quoted 300,000, whereas Humphries and Gordon, *Out of Sight*, (1992), p. 133 put the figure at 500,000.
[106] One of these women performed her civil duty with a good deal of seriousness and managed to 'track down' and report two men who had been using petrol illegally. *The British Deaf News*, Vol. 1, No. 5, (September-October 1955), p. 147.
[107] IWM Sound Archive 18274/4 Interview with Iris Hobby, 28th January 1999.

grow. In Leicester, a blind man and a single armed amputee took over an allotment as part of their contribution.[109] Others performed emergency work, with some deaf people trained as stretcher-bearers.[110]

Beyond the issues of employment, daily life in Britain provided difficult issues for disabled people, as they had their own set of unique problems. Air raids were one difficulty; how could those that could not walk get to the air raid shelters? As they were unable to hear the air raid siren, deaf people had to overcome a unique problem and ingenious methods were used. Some deaf people had toes tied with a long piece of string, the end of which was dangled out of a bedroom window, and when the warning sounded the ARP warden would pull heavily on the string in order to wake them up.[111] Others kept pets on their beds, and when the animal jumped at the sound of the siren, then its owner would know that it was time to take cover.[112]

Many disabled adults, therefore, found employment and new opportunities during the war. The situation for disabled children, however, was less clear. When it was announced that Britain was at war with Germany in September 1939, the planned evacuation of cities at risk was implemented, and those considered

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[108]Penny Summerfield, *Reconstructing Women's Wartime Lives*, (Manchester, 1998), p. 217-218.
[109] *The New Beacon*, (August 15th, 1940), p. 157.
[110] Many deaf volunteered for some form of National Service. *Deaf Quarterly News*, (January-March, 1940), p. 9.
[111] This system operated around Bristol. Gloria Pullen & Rachel Sutton-Spence, 'The British Deaf Community during the 1939-1945 War', in Renate Fischer & Harlan Lane, (eds.) *Looking Back*, (Hamburg, 1993), p. 173.
[112] Ibid, p. 173.

vulnerable were moved out. The groups were mainly comprised of able-bodied children and mothers, but 'cripples' too were included in the evacuated.[113] It was also deemed necessary to clear those who were in hospital beds taking up space that it was thought would soon be filled by war casualties. This was of especial concern for those with contagious diseases. Patients with sputum positive tuberculosis and other diseases were '...discharged wholesale from institutions without any arrangements having been made for their alternative treatment and care'.[114]

Many bed-ridden and disabled patients were sent back to their homes, despite the certainty of few facilities and an uncertain welcome when they got there. The Emergency Medical Service estimated that three hundred thousand casualties would require beds, so all patients who could walk were sent home.[115] As with the able-bodied families who vacated their homes, there was little organisation for the disabled apart from the initial evacuation plan.

Since children were the main targets for evacuation, those at residential schools for the disabled were also part of the movement away from major cities. However, the organisation adopted for disabled children was less ad hoc than that for those patients turned out of hospitals. In London, the Blanche Neville School for the Deaf was not evacuated until October 1st 1939 when it was

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[113] Calder, *The People's War*, (1997), p. 32.
[114] *British Medical Journal*, (March 22, 1941), p. 445.
[115] Brooke, 'Emergency Medical Service', Franklin Mellor (ed.) *History of the Second World War: Casualties and Medical Statistics*, (1972), p. 643.

relocated near Lowestoft. After the initial upheaval the School was moved even further away to north Wales, where it joined five other deaf schools, well clear of the bombing.[116] The Liverpool School for the Blind relocated itself the short distance to Rhyl.[117] Not all disabled schools evacuated. Some deaf schools such as the one in Leicester, closed while trenches were dug and air-raid shelters were built, and then re-opened, the children having been taught in their homes in small groups while these safety improvements were made.[118] Schools games equipment wore out, so it was difficult to continue with physical education.[119] The Leatherhead Royal School for the Blind's buildings were requisitioned by the government for the duration of the war, but those enrolled in training and at curative workshops were not evacuated, but boarded in a hostel close by in order that they could resume their employment.[120] There was little time for sport and games after long hours of working. Most of the evacuated schools and their pupils stayed where they were for the duration of the war. Some schools provided spaces for wounded soldiers to recuperate, yet at the same time continued with the business of educating children. The Heritage Craft School in Chailey took in hundreds of wounded men, just as it had during the First World War.[121] Some schools closed completely when war broke out. As an alternative

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[116] Sheila Smith, *Still Unique After All These Years*, (London, 1995), p. 23.
[117] Royden, *Pioneers and Perseverance*, (1991), p. 184.
[118] 'The Schools in War-Time', *The Teacher of the Deaf*, Vol. XXXVII, (December 1939), p. 220.
[119] When it was announced that no more plimsolls would be made the Ling Physical Association wrote to the Ministry of Education asking how children were expected to do physical training at school. Shoes made from rag waste were eventually sent to schools. PEA 1/7 Executive Committee Meeting, October 1, 1943.
[120] Royden, *Pioneers and Perseverance*, (1991), p. 184.
[121] Chailey also took in children either with raid shock or injured as the war progressed. Kimmins, *Chailey Heritage*, (1948), p. 8.

to school, children who normally lived with their parents were sent to hospitals or disabled children's homes for educational purposes. Vera Dean, who had cerebral palsy, was sent to Queen Mary's Hospital where she lived for the duration of the war.[122] Disabled children were not easily billeted and due to a lack of support some relocated day schools were forced to become residential.[123]

Whilst the seriousness and tedium of war was at the forefront of people's minds, there was still a place for recreation.[124] As J B Priestley said in his *Postscripts*,

> ..recreation should be planned and organised. We musn't allow ourselves to be reduced to living on an ever-narrowing edge of war-time existence, with nothing to think about but planes and tanks and guns. The gayer and richer the life we have to defend the more anxious we shall be to defend it.[125]

The playing and watching of sport became a contentious issue during the war.[126] John Anderson and his successor Herbert Morrison believed, like Priestley that sport and recreation were important for the overall health and welfare of the community. Despite criticism Morrison did not ban horse racing, but limits were

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[122] Vera Dean, *Three Steps Forward*, (London, 1957), pp. 17-83.
[123] Pritchard, *Education and the Handicapped*, (1983), p. 207.
[124] See Nick Hayes and Jeff Hill,(eds.), *Millions Like Us?*, (Liverpool, 1999), for an in-depth examination of culture and recreation during the Second World War.
[125] J.B. Priestley, *Postscripts*, (London, 1940), p. 93.
[126] Norman Baker, ' A More Even Playing Field? Sport During and After the War', Nick Hayes & Jeff Hill, (eds.), *Millions Like Us?*, (Liverpool, 1999), p. 130.

put on the number of meetings that could take place.[127] The British public found new and innovative ways to bet since the reduction in sporting competitions limited their gambling. A borough in London would take bets on the extent of the bombing damage when houses were checked after a night of bombing.[128] Sport still formed a part of the lives of the British during the war, although it was an effort to find facilities or an open space to play. It was hard to be a spectator because transport was difficult, top sportsmen often in the army and many of the sporting grounds had been turned over to the war effort. The All-England Tennis Club was a drill ground for the Home Guard.[129] Cliff Bastin, who played for England before the war and was unable to join the Forces due to his deafness said, 'What did matter was that the much-bombed, underfed people of Britain should be given entertainment'.[130]

Disabled people provided their own amusement despite physical recreation being severely curtailed. The blind held dances and rambling and rowing clubs still operated during the war.[131]

The only disabled people exercising with any regularity during the war were those that were being rehabilitated. However, not all exercise or games were sanctioned by the physical training instructors. While waiting for a new pair of

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[127] Robert MacKay, *The Test of War: Inside Britain, 1939-45*, (London, 1999), p. 188.
[128] For example there were odds of 10 to 1 against the chance of finding any house with all its windows intact. Ministry of Home Security and Ministry of Information, *Frontline 1940-41: The Official Story of the Civil Defence of Britain*, (London, 1942), p. 81.
[129] MacKay, *The Test of War*, (1999), p. 188.
[130] Cliff Bastin, *Cliff Bastin Remembers*, (London, 1950), p. 163.
[131] *The New Beacon*, Vol. 28, No. 330, (June 15th 1944), p. 103.

legs whilst at Roehampton, Colin Hodgkinson participated in a wheelchair race and crashed badly.[132] Other war wounded, such as those at St Dunstan's still participated in sports days during the war.[133] Sporting equipment could be used in an unusual manner during the war. One pilot filled his artificial legs with table tennis balls so that he would not sink if he crashed over the sea.[134]

To conclude, the Second World War, like the First had a significant effect on the disabled. While many from the First World War who had come back disabled could look forward to a life with little help, those returning from the Second were as likely as not to be rehabilitated and sent back to the fighting, or found another place in the war effort. Rehabilitation was important: it made government, associations and the disabled themselves believe that the chance to remain within society as a functioning employed citizen was possible, even after severe injury. Rehabilitation was so successful that it was extended to other groups during the war, and after it had ended. For those already disabled, the war presented them with some further opportunities especially in employment. Disabled people presented themselves as a willing workforce both in industry and also on the home front. Faced with a common enemy the war integrated disabled people with society in a way not seen previously. The challenge in the post-war years would be for disabled people to maintain their new place, and for those who had been disabled during the war to improve their situation through

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[132] Hodgkinson, *Best Foot Forward*, (1957), p. 90.
[133] *The New Beacon*, Vol. 28, No. 332, (August 15, 1944), p. 154.
[134] Problematically, they had a tendency to explode at altitudes over 30 000 feet. Hodgkinson, *Best Foot Forward*, (1957), p. 140.

their ongoing rehabilitation. In both these goals, sport and physical exercise was to play a key part.

Chapter 4
Rehabilitation in Practise: Stoke Mandeville Hospital 1944-1950

Rehabilitation was the most important aspect of physical treatment of the 1940s. Much of early physical rehabilitation was confined to remedial exercises, as we saw in chapter three, and had been expanded to include sport and games as the war progressed. Nowhere was it used so effectively and with such dramatic results than on those with paralysis at the Spinal Unit of the Stoke Mandeville Hospital in Aylesbury. Stoke Mandeville was a microcosmic[1] example of how rehabilitation methods could be made to work for people with serious disabilities. This innovation was attributed mainly to Ludwig Guttmann, a nerve specialist, who opened the Spinal Injuries Unit at Stoke Mandeville Hospital in 1944. This chapter will trace the establishment of the Unit and examine the treatment, including the development of remedial games that was provided for the spinal injured by Guttmann and his team. The emphasis on games and sport in the rehabilitation of the paralysed will be contrasted with the rehabilitative sporting interests of other disabled groups at the time, notably the blind.

While physical activities were important at Stoke Mandeville, it must always be borne in mind that the whole process at the Spinal Unit had a medical basis. Patients were examined, experimented on and sports were developed specifically for their curative mental and physical value. While the medical benefits of remedial games were still paramount in treatment, the sports

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[1] There were only 650 spinal paralysed as a result of the Second World War. Ludwig Guttmann, *Spinal Cord Injuries: Comprehensive Management and Research*, (Oxford, 1973), p. 7.

themselves progressed to a formal competition and the Stoke Mandeville Games became a regular feature of the summer after 1948. As well as the obvious physical benefits of a fitter, stronger body, Guttmann felt that participation in sport and games could minimise disability in the eyes of the able-bodied, thereby helping the paralysed to take up employment and gain independence in mainstream society. Sport and games had more benefits for the spinal paralysed than the merely recreational.

As we saw in the previous chapter, remedial exercises interspersed with some sport to break up the monotony were being established in rehabilitative centres throughout the war. There were, however, some areas where it was not considered safe or worthwhile to attempt rehabilitation through either physical exercise or sport. One of these was the field of spinal injury and resultant paralysis.[2] Prior to the 1940s the likelihood of death within the first few months of a patient incurring a spinal injury was between 47 and 65%.[3] Within three years the death rate had increased to 80%.[4] Death usually resulted not from the accompanying paralysis, but complications of bed sores and urinary tract infections. Most patients had to be confined to a bed in hospital, and the routine of a paralysed patient generally consisted of massage to help the pain of their contorted limbs, and in some cases, some occupational therapy such as rug

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[2] As long as there was no damage to the spinal cord, the patient could recover fully from a broken spine. It was the resultant paralysis and its complications that doctors were unable to treat.
[3] Guttmann, *Spinal Cord Injuries: Comprehensive Management and Research*, (1973), p. 5.
[4] R.O. Ward, 'The Management of the Bladder in Spinal Injuries', In Hamilton Bailey, (ed.), *Surgery of Modern Warfare*, (Edinburgh, 1944), p. 661.

making.[5] Due to wasting from lack of exercise, patients were often unable to sit up, so their quality of life was greatly diminished. Wheelchairs were at a very early stage of development and even fewer patients had access to a spinal carriage. Where these were available, the patient would lie flat or raised up slightly on pillows, on a mattress inside the spinal carriage. This resembled an enormous adult sized pram, which a nurse or attendant would push around. In the case of particularly mobile patients, two sticks were placed either side of the carriage, thereby enabling them to push themselves, with a motion reminiscent of a skier. Generally though, it was felt that those who had suffered a spinal injury with paralysis were hopeless cases. For those who surmounted the odds so heavily stacked against them, and survived beyond three years, their lives were often painful and lonely.

> Most of those who managed to survive were doomed to spend the rest of their lives as pensioners at home or in institutions for incurables dependent on other people's assistance, and, as a rule, given no incentive or encouragement to return to a useful life.[6]

Even the doctors whose job it was to treat the spinal injured felt that there was

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[5] Being forced to lie down when disabled was not confined to the spinal paralysed. Other disabled people were required to spend a large part of their time recumbent. Vera Dean who had cerebral palsy was forced to spend a significant amount of time in bed in hospital. Vera Dean, *Three Steps Forward*, (London, 1957).

[6] Susan Goodman, *Spirit of Stoke Mandeville*, (London, 1986), p. 98.

little that they could do to improve the life of their patients. A physiotherapist detailed the hopelessness one doctor experienced when dealing with them.

> I well remember an orthopaedic surgeon telling me how much it distressed him that all he seemed able to do for these patients was to discuss the string bags which they were making.[7]

The making of string bags was part of the long tradition of occupational therapy for those paralysed, but generally the other rehabilitative methods, such as remedial exercises and active forms of physiotherapy were not used. These new methods of treatment that were being tried by an increasing number of doctors on disabled people with previously untreatable damage bypassed those with spinal injuries until the war was almost over. As we will see as the chapter unfolds, work towards rehabilitative care for the spinal injured was taking place, but the treatment of patients was not realised until 1944.

This was not to say, however that there were not exceptions to the widespread sense of hopelessness experienced by the spinal injured. Some people with a paralysis managed their disability well and lived relatively full lives.

> I began to live a normal life again, going out in a wheeled-chair and being carried from a car to visit friends and cinemas and theatres. I even started

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[7] *The Cord*, Vol. 17, No. 1, (Winter 1964/65), p. 40.

> going to a few dances again and watching others doing what I had loved best of all before...[8]

Certain victims of spinal injury and its resulting paralysis were obviously better placed than others, having more resources to pay for treatment and assistance at home. Good medical care and a healthy diet ensured that for some, a setback as devastating as a spinal injury might not have such long lasting weakening effects. For those that could not afford a reasonable standard of care, a life in an institution or hospital was the only remedy.

Eventually, rehabilitative treatment began to be applied to the spinal injured, but it must be borne in mind that the treatment was small scale and limited to specific groups in specialist units.[9] The first of these hospitals was the Stoke Mandeville Hospital near Aylesbury. While treatment was applied in the latter stages of the war, at places like Stoke Mandeville, the development that culminated in treatment began much earlier. In 1939, the neurosurgeon Dr Ludwig Guttmann and his family escaped Jewish persecution in Germany owing to the efforts of The British Society for the Protection of Science and Learning.[10] Upon his relocation to Britain, Guttmann continued his research on the function of sweat glands and electrical stimulation of paralysed muscles in relative anonymity in

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[8] *The Cord*, Vol. 3, No. 1, (Autumn 1949), p. 26.

[9] Throughout the war, twelve spinal units were established at Warrington, Basingstoke, Sheffield, Leeds, Worcester, Newcastle, Cardiff, Llandrindod Wells, Edinburgh and Stanmore and Leatherhead outside London as well as Stoke Mandeville. That is not to assert however, that the treatment at these other institutions was the same as Stoke Mandeville. Guttmann, *Spinal Cord Injuries*, (1973), p. 7.

[10] An account of Guttmann's life can be found in Goodman, *Spirit of Stoke Mandeville*, (1986).

Oxford. In the early stages of the war, he was asked by his colleague Dr George Riddoch, Chairman of the Nerve Injury Committee of the Medical Research Council, to write a review of surgery of spinal injuries and the recovery of the nervous system after injury, and a survey on rehabilitation in cases of spinal cord injury.[11] This report, detailing Guttmann's proposal of methods of treatment was submitted to the Peripheral Nerve Committee[12] of the Research Council in that year. Guttmann possessed what the Committee considered radical ideas about the treatment of spinal injury. Essentially he believed that an experience that he had while working in a hospital whilst still in Germany had formed the basis of his thinking about their treatment. The case was that of a young miner, who had had his spinal cord crushed in an accident and died, not from his injuries, but from complications.

> During the following weeks I saw this fine, strong man rapidly deteriorate and become increasingly emaciated as a result from sepsis from urinary infection and sloughing, multiple bedsores until he died just five weeks after his injury.[13]

The Committee was obviously impressed with the idea that he could cure these patients by using normal rehabilitative practises and some surgery. Guttmann

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[11] There are arguments surrounding the year in which the reports were requested, Guttmann cites 1939, while other sources state it was 1941. IWM Sound Archive 4596/03, Interview with Ludwig Guttmann, 18 February, 1980.
[12] Interestingly, Guttmann assisted in the establishment of this Committee in 1939. Ludwig Guttmann, 'Services for the Treatment and rehabilitation of Spinal Paraplegics and Tetraplegics in Great Britain', *Trends in Social Welfare*, (Oxford, 1965), p. 319.
[13] Goodman, *Spirit of Stoke Mandeville*, (1986), p. 29.

had their confidence and they recommended he put his theories into practice. In 1943 a request to the government was submitted to open a specialist spinal unit, and Guttmann chose the site at Stoke Mandeville as the location to set up this new centre.[14] The Stoke Mandeville Unit for the Spinal Injured was opened in February 1944 with little fanfare, one ward and twenty-eight beds.[15] This small number would soon be augmented as the Unit had been opened specially to treat the many casualties expected from the D-Day landings.[16]

Why did the Medical Research Council call for a report in order to radically change their current treatment of the spinal paralysed? Although Guttmann assumed that the mantle of radical treatment for the spinal injured as entirely his, there may have been other reasons that influenced the change in approach. One factor may have been how the armed forces had responded to the problem of spinal injuries. The number of servicemen surviving severe injury and becoming disabled was higher as a result of new drugs and techniques, so those with spinal injury who had previously died, were surviving their initial wounds. The British had previously chosen to use orthopaedic surgeons to treat the spinal injured, apparently considering that the spine should be attended to like a broken bone, and in many cases where there had been no damage to the spinal cord, this would have been an acceptable method of treatment. But where there had

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[14] The EMS acquired the hospital in 1939. Originally the Stoke Mandeville Hospital had been a centre for contagious diseases and later for war wounds and plastic surgery. See J.P. Reidy, 'The Formation and Early History of the Stoke Mandeville Plastic Surgery Unit', *British Joumal of Plastic Surgery*, Vol. 39, (1986).

[15] Elvira P.G. Hobson, *Physiotherapy in Paraplegia*, (London, 1956), p. 2.

[16] By August 1944, there were 50 patients at Stoke Mandeville. John Surtees, *Chaseley: A Home from Home*, (Eastbourne, 1997), p. 13.

been impairment to the spinal cord, the orthopaedic surgeons had to attempt to treat the resultant paralysis, which they were not very well equipped to do. There were not merely broken bones that required healing, but a whole system of treatment particular to a mass of injured and sometimes severed nerves, which required a specialised form of treatment. The change by the British to using neurosurgeons for the treatment of the paralysed may also have been the influence of the Americans who used neurosurgeons to treat the spinal injured. It was argued that the number of casualties that American orthopaedic surgeons were treating, meant they would be unable to effectively treat such specialised cases as the spinal injured,[17] and as a result the neurosurgeons had been drafted in to treat them. The British Medical Services had worked closely with their American counterparts after their entry to the war in 1941.[18] The request by the Peripheral Nerve Committee for Guttmann's report may have been brought about in part by the Americans use of neurosurgeons in the treatment of paralysis.[19] As in so may other cases, the war was to the key that unlocked new knowledge into innovative forms of treatment for the paralysed.

The treatment that Guttmann followed was radical in that it had not previously been used on those with paralysing spinal injury, but instead was a combination of contemporary rehabilitative practises.[20] It was not so much the previous

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[17] Medical Department, United States Army, *Surgery in World War II, Vol. II, Neurosurgery*, (1959), p. xii.
[18] Ibid, p. xii.
[19] There is no actual evidence of this, but the timing of the call for Guttmann's report (of which no copy exists) and the American's entry appear to be causal.
[20] PRO FD 4/88, Medical Research Council Report, *Injuries of the Spinal Cord and Cauda Equina*, 1924. This book identified both urinary tract infections and bedsores as a problem for

medical treatment of the patients was poor, it was that none of the new rehabilitation methods had been applied to those with spinal injury and resulting paralysis. Many of the medical problems of the patients were solved by common sense methods. To prevent bedsores patients were turned in their beds regularly. This was very labour intensive as moving a patient took four orderlies and a supervisor.[21] The problem of infection of the urinary tract was solved by regular disinfecting of the urinary system or in some cases by installing supra pubic catheters, which were fitted directly into the bladder above the pubis.[22] As we saw in Chapter Three, new drugs also fought infections, and this was particularly helpful in the treatment regime of the spinal paralysed. With his Oxford connections, Guttmann was able to obtain penicillin in limited amounts, as Lady Florey would bring small supplies of the drug to Stoke Mandeville.[23]

Guttmann also had a limited influence in what happened to those with spinal injury and paralysis prior to arriving at his Spinal Injuries Unit. In the Services, plaster beds had been the normal method for transporting those soldiers with spinal injury. These were hard boards made of plaster of Paris that, it was believed, would prevent the patient moving easily and kept the spine still and straight, therefore preventing any further damage. This method was acceptable if there was merely a broken bone, but was devastating on a patient who had

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those with spinal injury during the First World War and suggested ways in which they might be avoided such as using 'water mattresses'.

[21] Hobson, *Physiotherapy in Paraplegia*, (1956), p. 12.

[22] Supra-pubic catheters were sometimes removed after bladder control was regained. *The Cord*, Vol. 2, No. 1, (Autumn, 1948), p. 23-28.

[23] Joan Scruton, *Stoke Mandeville: Road to the Paralympics*, (Aylesbury, 1998), p. 41.

suffered paralysis. The resulting loss of sensation would mean that he would not feel pain from pressure, and bedsores were the result. Generally, patients were being transported back to Britain reasonably quickly but a week on a plaster bed was detrimental to the condition of even the most robust.[24] On return from a distant theatre such as Asia, the soldier could be lying catheterised on a plaster bed for several weeks, without being moved. As soon as the patient arrived at Stoke Mandeville, he was placed on pillow packs and moved regularly. Guttmann's suggestion to the Services was that they use pillow packs as the plaster beds were contributing to the pressure sores, and there was a change in the previous practice.

From its establishment in 1944, the daily routine of the Spinal Unit was a combination of contemporary rehabilitative practises and some new treatments devised by Guttmann. Despite an initial lack of enthusiasm from the staff who were of the opinion that there was little that could be done for these patients, active physiotherapy and remedial exercises were adopted in favour of the gentle massage of contorted limbs and bed rest.[25] Patients were encouraged to exercise in bed as soon as they could manage. In addition to these remedial exercises, Guttmann also instructed his staff to throw medicine balls at the patients while they were still confined to bed.[26] Special equipment like the Stoke

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[24] During the D-Day landings, in 90% of cases the time from wounding to arrival in a British hospital was one week. Crew, *Army Medical Services Campaigns, Vol. IV*, (1962), p. 615.
[25] Ludwig Guttmann, 'Victory Over Paraplegia', Ian Fraser, (ed.), *Conquest of Disability*, (London, 1956), p. 65.
[26] Goodman, *Spirit of Stoke Mandeville*, (1986), p. 143.

Mandeville bed cycle was developed for these exercises.[27] Whilst the patient was still in the ward, the curing through competitive activity began. It must be borne in mind that all of Guttmann's original patients were young male ex-servicemen who had been injured during the fighting, and were often eager to outdo one another. Guttmann managed to exploit the competitive instincts of the men in order to get them to participate in their treatment. Exercise sessions were carried out in the wards in an attempt to encourage others who were not as advanced in their activities.[28] Competitions held in the wards included the timed 'dressing exercises' where the patients had to get out of bed, dress themselves and get into their wheelchair.[29] When the patients were able to move around, they were transported to the physiotherapy room, where they were treated to a round of movements and exercises that would help them regain some control of their muscles, firstly in the Guthrie-Smith apparatus.[30] Once some control and muscle development had been established, the exercises became more advanced. Patients would practise hitting a punchball and would also perform more difficult tasks, such as pulling themselves upright and using their arms to support themselves between parallel bars. The idea behind these forms of movement was that the patient would be able to develop some compensatory muscles especially in the upper torso, in order to be able to sit up in a

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[27] This equipment looked somewhat like a regular bicycle and was attached above the patient's bed. The patient gripped handles with his hands, and his feet and legs were attached to a type of pedal, which the patient rotated. Hobson, *Physiotherapy in Paraplegia*, (1956), p. 30.
[28] *The Cord*, Vol. 17, No. 1, (Winter 1964/65), p. 71.
[29] The record for the dressing competition stood at four minutes. Guttmann, 'Rehabilitation After Injuries', in Guthrie-Smith, (ed.), *Rehabilitation, Re-education and Remedial Exercises*, (1949), p. 445.
[30] The Guthrie-Smith Apparatus is described in Chapter Two.

wheelchair. Most patients at Stoke Mandeville had wheelchairs for their use from 1944. They were large and cumbersome; weighing about fifty pounds and looking rather like leather armchairs on wheels. In fact the wheelchairs provided were so heavy that they usually had to be pushed, so it was virtually impossible for any patient to venture out of the hospital grounds on their own.

The effect of a permanent disability upon these young, previously fit men could be devastating.[31] Not for them a return to their previous lives after the upheaval of war, instead it had left a physical, permanent mark. Many were severely depressed and some actually attempted suicide. It was part of the function of the doctors, nurses and physiotherapists to try to instil some notion of hope into these radically changed lives. For those at Stoke Mandeville, as well as those at other rehabilitation centres, the restoration process extended to the mind as well as the body. Steps were taken to minimise distress. The service sub-committee of the Research Board for the correlation of medical science and physical education noted,

> The importance of the morale factor cannot be overstressed. It is essential to remove the inertia and despondency of hospitalisation and to

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[31] Service women in small numbers were also taken to Stoke Mandeville for treatment of their spinal injury. There are no records of actual numbers, but immediately following the war there appear to be about six.

> restore this will to get well.[32]

Guttmann heartily endorsed this sentiment.

> The creation of a cheerful atmosphere and good morale in the ward cannot be stressed too much. The whole unit must be deliberately impregnated with enthusiasm.[33]

Cheerfulness and positive thinking, while maintaining a happy atmosphere for the patients did not serve to counter boredom. At Stoke Mandeville, the patients themselves devised many activities in order to pass the time that could weigh heavily on the paraplegics. Repetitive exercises and physiotherapy were not enough to amuse and stimulate them. Instead they amused themselves with a variety of activities, including a dramatic society, and in 1944 a choir was established and the hospital was treated to carols at Christmas.[34] Volunteers and staff at Stoke Mandeville would also try to give the patients some sort of social life; for example the staff would regularly push them to the pub in the evenings. When numbers at the hospital increased, fortunately there was no shortage of helpers as 'the war-time spirit was very much in evidence and these severely disabled ex-servicemen were welcomed everywhere' and there were

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[32] CMA SA/RBC C 7.4, Service Sub-Committee of the Research Board for Correlation of Medical Science and Physical Education, *Report on the Wounded and Disabled*, Part III, March 15, 1944.
[33] Ludwig Guttmann, 'The Treatment and Rehabilitation of Patients with Injuries of the Spinal Cord', in Zachary Cope (ed.), *History of the Second World War*, (London, 1953), p. 499.
[34] Scruton, *Stoke Mandeville*, (1998), p. 19.

plenty of people to help push them around.[35] This was no mean feat as the chair and occupant made a heavy weight. Trips to the local cinema in Aylesbury were regular events, and as there was no section in which those in wheelchairs could sit, they all had to be taken out of their chairs and carried to their seats. One of the original patients recalled,

> ...the patience of the attendants at the local cinema would be required to lift as many as six of us at a time into seats.[36]

Films were also delivered to the hospital and shown weekly. Many famous entertainers came in person to Stoke Mandeville, such as Dame Margot Fonteyn and a group of colleagues from the Royal Ballet who came and danced for the patients after the war.[37]

Other activities were organised in an attempt to put more meaning and purpose into patient's lives. A special paraplegic branch of the British Legion was established at the hospital in 1945 when the war ended. Two years later, the branch was responsible for the establishment of a magazine, which they named *The Cord*, whose purpose was to keep paraplegics aware of changes, especially in services for disabled people, as well as communication and the establishment of solidarity in paraplegia. *The Cord* was full of medical advice, such as how to

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[35] Surtees, *Chaseley*, (1997), p. 31.
[36] *The Cord*, Vol. 17, (Winter 1964/65), p. 61
[37] Scruton, *Stoke Mandeville*, (1998), p. 23.

avoid the complications of paraplegia, like bedsores and recurring urinary tract infections. Guttmann was a regular contributor on these medical aspects. Other useful articles included information about pensions, taxation and employment opportunities. A gossip column and stories were often contributed, as were rounds of engagement and wedding announcements. News from the affiliated homes was also a regular feature, and ribald gossip about their activities abounded. *The Cord* was important, as it helped to re-establish those feelings of normality.

Permanent and institutionalised hospital life was no longer the fate of those with paralysis from spinal injury, although treatment took a long time; some patients took four years of treatment before they were finally ready to leave the hospital. After the course of treatment was finished, a few patients returned to their homes, and others moved to affiliated institutions that had been established to house the rehabilitated. At these places, expert care was on hand should it be required, but the spinal injured could live and work with a degree of independence. Some of the inmates lived there permanently, continuing to live a life surrounded by their peers, who fully understood what it meant to be a paraplegic. Some of the homes were located in what used to be large private houses, for example, Chaseley Home in Eastbourne provided accommodation for single men who had left Stoke Mandeville. Chaseley's original purpose was to have been a convalescent home for 'blinded' soldiers, but Guttmann was able to persuade the owner, Lady Michaelis to give her house and fifty thousand pounds

to help with its maintenance to benefit paraplegics.[38] It opened in 1946, as did a spinal section at the Star and Garter Home in Richmond, which was operated on behalf of the Ministry of Pensions.[39] In the same year Lyme Green Settlement was established in Macclesfield by the British Red Cross and the Order of St John, and was also partly funded by private donations.[40] Both Lyme Green and Kytes Estate[41] near Watford were settlements where special adapted homes were built in the late 1940s for both single ex-servicemen and also for those with families.[42] They were also located close to potential employment opportunities at industrial parks nearby.[43] The Duchess of Gloucester House, previously the Osterley Hotel, opened in 1949, and provided a home for single men, operating in a very similar way to Chaseley.[44] Stoke Mandeville's influence in the sphere of spinal injury extended to Scotland in 1950, when the Thistle Foundation opened its first spinal unit.[45] The influence of Stoke Mandeville was always near as Guttmann was the consultant attached to all of these homes, and patients whose condition relapsed could always be sent back to Stoke Mandeville Hospital for treatment. The patients continued to practise activities in their new accommodation, which meant that their level of fitness was not impaired by a move away from the Spinal Unit.

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[38] Surtees, *Chaseley*, (1997), p. 15.
[39] As mentioned in Chapter One, the Star and Garter first opened in 1916. *The Star and Garter Home Annual Report*, 1950.
[40] *The Guardian*, July 14, 1945. A notice announcing the opening also appeared in *The Lancet*, (July 21, 1945), p. 95.
[41] Although Kytes Estate was associated with Stoke Mandeville, it did not participate in many of Stoke Mandeville's sporting activities.
[42] *The Cord*, Vol. 1, No. 1, (Autumn, 1947), p. 10-13.
[43] Kytes opened in 1947. *The Cord*, Vol. 17, No. 1, (Winter 1964/65), p. 27.
[44] *The Cord*, Vol. 3, No. 3, (Spring , 1950), p. 8.
[45] Scruton, *Stoke Mandeville*, (1998), p. 49.

The establishment of these homes for the paralysed demonstrated the degree of independence which those with a severe disability could gain. Unlike those who had suffered the same injury in the earlier part of the century, these patients could look forward to a life of increased mobility and autonomy. Employment, and with it financial security, was considered the ultimate symbol of full rehabilitation, and many patients at Stoke Mandeville achieved this aim. Like all other centres of rehabilitation, Stoke Mandeville had an Occupational Therapy department where patients were able to learn carpentry and practise other skills.[46] Some of them were sent out on work placements from the early stages of Stoke Mandeville's establishment where they tried to put in a full day of work.[47] Many of the settlements set up for paraplegics after the period of hospitalisation were located reasonably close to factories and industrial areas where the patients could try to find employment.[48] Although those hospitalised at Stoke Mandeville were ex-servicepersons and therefore entitled to preferential employment under the Disabled Persons (Employment) Act 1944, work was not always easy to procure. There were reasons for this. Transport was problematic, especially immediately following the war, and the dimensions of the wheelchair hampered access to buildings. Continuity in employment was difficult to maintain as health breakdowns were common; patients had problems with their early supra pubic

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[46] Hobson, *Physiotherapy in Paraplegia*, (1956), p. 84.
[47] The first of these was in 1944. Guttmann, *Spinal Cord Injuries*, (1973), p. 10.
[48] Both Kytes and Lyme Green were located in proximity to industries. Guttmann, 'Services for the Treatment and Rehabilitation of Spinal Paraplegics', *Trends in Social Welfare*, (1965), p. 329-330.

catheters, and a bedsore could have a patient hospitalised for months. However long it took, the independence gained from having a job was a goal that the majority of the patients at Stoke Mandeville attempted to achieve.

Whilst working towards their full rehabilitation with a job and independence as their target, patients had to find something to do. In the early days of the hospitals any work experience was sporadic, fitness from treatment slow, and the choir, the cinema and films were not enough to prevent boredom. It was here that recreational games and activities became a popular form of passing the time. The patients at Stoke Mandeville played darts, skittles and snooker, and during their visits to the pub would play these games.[49] These popular pub activities were easy to play in a wheelchair, as they did not require much movement. As we have seen, recreation was an important component of the rehabilitation of the individual, so that the mind and body were both restored. The socialisation provided by playing games was both an important aspect of recovery and leaning to fit in to society in a wheelchair.

The first moves toward more active sport and games for the paraplegic disabled came not from the medical establishment, neither doctors nor physiotherapists, but from the patients themselves. Two incidents had an impact on the development of sport for those in wheelchairs. In 1944; Guttmann watched from a window while the staff had a break outside in the sun, throwing a ball to each

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[49] Hobson, *Physiotherapy in Paraplegia*, (1956), p. 83.

other. As the patients watched this group of able-bodied play, the staff started including some patients in the game.[50] Guttmann noticed the body movement of the patients and how the effort of catching the ball made them bend and stretch. After this incident in the summer of 1944, throwing balls became part of the patients exercise regime. The throwing of balls as therapy was not new, as many patients had experienced medicine ball throwing while in the wards. So while medicine ball throwing was part of the treatment on the wards, it had not extended to therapy in the gymnasium, and it was the patients who gave Guttmann the idea. On another separate occasion, again in 1944, Guttmann discovered a number of patients on a piece of flat ground at the back of the hospital. They had upended walking sticks so the curved handle was on the ground and they were pushing themselves around in their wheelchairs, attempting to hit a wooden puck.[51]

Guttmann saw this game as another way to alleviate the boredom, and depression of young men, previously fit, who now found themselves confined to wheelchairs for the rest of their lives. More importantly, as a doctor, Guttmann realised that strong bodily movements could be disguised in the enthusiasm for the game.[52] A keen sportsman himself, Guttmann had run, played football and been a skilled fencer while at university. Even for an enthusiastic sportsman, this variant of able-bodied sport was a somewhat different and difficult prospect.

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[50] Surtees, *Chaseley: A Home from Home*, (1997), p. 60.
[51] Goodman, *Spirit of Stoke Mandeville*, (1986), p. 142.
[52] Guthrie-Smith, *Rehabilitation, Re-education and Remedial Exercise*, (1949), p. 3.

Guttmann got into a wheelchair in the gymnasium and began to practise what he dubbed 'wheelchair polo'.

> I tried to move about and, using the curved handle of a walking stick hit the ball and chased after it. Simultaneously, I tried to prevent my opponent in another wheelchair...from counteracting my movements.[53]

There seems to be no definitive reason why the game was called 'polo' and not hockey, as it could easily have been taken for a game of hockey. The notion of the wheelchair as a type of transport or 'horse' may have given rise to its name. Whatever its title, this game was the first in Britain that was developed specifically for wheelchair players.

Wheelchair polo began to be played regularly at Stoke Mandeville, pitting patients against orderlies and physiotherapists. There appeared to be no particular structure to the competitions, there were no team names nor schedule of games. The large ungainly wheelchairs hampered the sporting competition and were responsible for a lot of frustration, but the games were entered into with a great deal of enthusiasm nevertheless. Even Occupational Therapy became involved in wheelchair polo; in July 1945 the woodwork department made goal posts with nets and twelve mallets for would-be participants.[54] But the game eventually had to be abandoned.

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[53] Goodman, *Spirit of Stoke Mandeville*, 1986.p. 142.
[54] *The Cord*, Vol. 17, No. 1, (Winter 1964/65), p. 56.

> ...because of possible head injuries being caused by the excitement created by the game, the swinging mallet frequently being in contact with the heads of the players.[55]

The players did not share this concern for their safety.

> If you didn't come out of your chair at least once during the course of this game; you were considered by the other lads to be a cissy.[56]

Although wheelchair polo only lasted a few months, it had an important impact, as it was the first wheelchair team sport played in Britain. By early 1945 it had been replaced by wheelchair netball.[57]

Although wheelchair polo may have failed as a long-term activity, the games in the gymnasium had whetted the patient's appetite for more. Most of these new sports were devised and selected mostly by Guttmann, and medical considerations were the main reason for play. Guttmann chose archery because it built up compensatory muscles in the torso, therefore strengthening the patient's upper body. It was an interesting, non-contact sport, which did not

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[55] *The Cord*, Vol. 17, Vol. 1, (Winter 1964/65), p. 57
[56] Ibid, p. 60-61.
[57] Although it was named netball, from photographs and descriptions of the game, it appears that the game was wheelchair basketball, which was played in the USA. Guttmann, *Textbook of Sport for the Disabled,* (1976), p. 23.

require a great deal of equipment, and patients could devote as much or as little time to it as they wished. It was also an activity in which the able-bodied and disabled could play together, as well as men and women, which was also a consideration. In order to get as many patients interested in the sport as possible, Guttmann invited the champion English archer Frank Bilson to Stoke Mandeville, to teach the patients, and the physical instructors, how to shoot.[58] Archery proved a popular pastime and as with wheelchair polo, the Occupational Therapy department was put to good use in constructing suitable equipment.[59] As with many activities at Stoke Mandeville, there was an element of rivalry in archery, and an ad hoc competition between the different wards, but it was not until later that this sport would be the start of an international sporting competition for the spinal paralysed.

On July 28, 1948 an archery competition was held on the lawns outside Stoke Mandeville.[60] The Star and Garter Home's Spinal Unit was entertained to a match, as remedial exercise and sport were practised at all of the Homes in which Guttmann was a consultant.[61] Sixteen competitors were involved in total, two of who were women from Stoke Mandeville.[62] The Star and Garter emerged victorious, and were awarded the Challenge Shield, which was specially made

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[58] The Cord, Vol. 17, No. 1, (Winter 1964/65), p. 43.
[59] Parker, *The Cord*, Vol. 17, Winter 64/65.p.57.
[60] The archery competition was held on the same day as the opening ceremony of the 1948 London Olympics
[61] Guttmann was also a consulting surgeon at the Star and Garter Home in Richmond, and he also persuaded Frank Bilson to instruct there and procured equipment in order for those at the Star and Garter to practise.
[62] Joan Scruton, 'Sir Ludwig Guttmann: Creator of a World Sports Movement for the Paralysed and Other Disabled', *Paraplegia*, Vol. 17, No. 1, (May 1979), p. 52.

for this first contest. While archery eventually became an important sport for the disabled as it was used to make paralysed people more visible to the able-bodied, the shooting was only part of the festivities at Stoke Mandeville that day. The main focus of the celebration was a visit from the Minister of Pensions. Hilary Marquand was going to present the patients with a 'Paraplegic Bus' so that they could go on outings.[63] Both reports in the *Bucks Herald* and *The Cord* focussed on the Minister's visit and the gift of the bus.[64] There was no indication that this was in any way a significant moment for organised disabled sport, nor any suggestion that any organised regular competition might evolve from it.[65] Archery was mainly a different remedial exercise, which built up muscles in the body, particularly the area above the lesion, and it was more interesting for the participants than repetitive movements. However, the 1948 competition had been a popular event, and the patients expressed an interest in having one like it the following summer. When the decision was made to hold another competition in 1949, the numbers taking part had increased to sixty.[66]

As there was no visit from the Minister of Pensions in 1949, the archery and netball competitions received little coverage outside the individual hospitals and Homes, although there was a report in *The Cord.* As well as the number of participants increasing, the new sport of wheelchair netball joined archery in the calendar of events in 1949. Although it had replaced wheelchair polo some time

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[63] *The Cord*, Vol. 1, No. 4, (Summer 1948), p. 23.
[64] The *Bucks Herald* got Guttmann's initial wrong, citing it as 'H'. *Bucks Herald*, (August 6, 1948).
[65] In fact, a return match between the Star and Garter Home and Stoke Mandeville was held in September 1948.

previously, it had not been played at the first sports day. The faster paced netball proved more popular than sedentary archery with the gate-paying spectators.[67]

> Netball, in particular, seems very well patronised. It seems to be as good a crowd-drawing game as soccer.[68]

Although each team was comprised of ex-servicepeople, a woman's only team and a group of Polish men also competed at the 1949 Sports Day in the archery rounds. The women were drawn from paralysed servicewomen at Stoke Mandeville and the Polish soldiers came from a home in Penley in Wales.[69] Neither team excelled on the day but *The Cord* reported the 'sporting' attitude of the Poles adding that it was far from surprising that the Poles had not done well as they had had little practise at archery.[70]

The enthusiasm for paraplegic sport continued to grow and after 1949, the Games became an established event, with many more participants and new activities each year. While these events achieved a certain degree of modest publicity, games and activities at the Spinal Unit and affiliated homes continued to form part of the treatment regime. In 1950, the sports day was renamed the Stoke Mandeville Festival of Sport after the British Festival of Sport.

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[66] Goodman, *Spirit of Stoke Mandeville*, (1986), p. 149.
[67] *The Cord*, Vol. 3, No. 1, (Autumn 1949), p. 24.
[68] Ibid, p. 23.
[69] Penley was also administered by the Ministry of Pensions and formed a hospital and rehabilitation centre for Polish soldiers who had fought under British Command since 1942. See PRO MH 120/8 History of Penley, (undated but probably 1961).
[70] *The Cord*, Vol. 3, No. 1, (Autumn, 1949), p. 22.

Representatives both of the hospital and the Star and Garter Home had participated in sporting demonstrations during the course of the Festival when two teams of paraplegics played a game of wheelchair netball in front of a crowd of ten thousand at the Empress Hall in London.[71] At that same event, disabled archers also shot against some of the top archers in England.[72] The event had given the spectacle of competitive paraplegic sport its first real public exposure. This widening of awareness had an effect on the numbers of participants at the 1950 Festival at Stoke Mandeville when victims of industrial accidents were allowed to take part for the first time. They were mainly coal miners from the north of England who had suffered spinal paralysis due to accidents underground.[73] The wider reach of the competition coincided with expansion in several sports, and for the first time the Olympic sport of javelin joined archery and netball as a main event.[74] Like archery, javelin was used in therapy for building up muscles in the upper torso and arms, but it was more exciting for the patients than remedial exercises, the spirit of competition, so important at Stoke Mandeville, adding to the fun. As the popularity of the contest grew, the level of competition intensified and teams worked to improve their standards.[75] While it would be misleading to suggest that competitors at the Stoke Mandeville Games

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[71] The event was organised by the CCPR. *The Cord*, Vol. 3, No. 4, (Summer, 1950), p. 9-10.
[72] *The Cord*, Vol. 3, No. 4, (Summer, 1950), p. 10.
[73] *The Cord*, Vol. 3, No. 4, (Summer, 1950), p. 19.
[74] Archery was not an Olympic sport at that time, although it had been in the 1900, 1904 and 1908 Games. At Antwerp in 1920 it was included but then it disappeared again until the Munich Olympics of 1972. *Chronicle of the Olympics*, (1998), p. 223-284 (results pages). Whereas javelin was an individual event in the Olympics, javelin throwing at Stoke Mandeville was a variation on the able bodied event, as it was the combined score of a team of two.
[75] Whereas in 1949, *The Cord* had referred to the Polish soldiers as 'sporting', the following year they took the Archery Shield and continued to be champions for several years afterwards.

practised religiously for their once a year outing, training did take place, and some Homes were more focussed on the events than others, and clearly they were encouraged to do so by the hospital as part of their rehabilitation and on-going fitness programme. While sport formed part of the experience for the patients at Stoke Mandeville, and many were enthusiastic about it, the Spinal Unit concentrated more heavily on its sport programme.

Although Stoke Mandeville was successful, and its sporting endeavours achieved some public recognition, it was not necessarily an exemplary rehabilitation centre as far as its attitude toward the government plan of employment was concerned. Although sport and exercise was important for the ex-servicemen's recovery, the main object of rehabilitation centres was to assist their patients' back to the workforce and an independent life. On this subject, the views of Guttmann and those of the various Ministries diverged. In 1948, a representative of the Ministry of Labour went to Stoke Mandeville to examine levels of training in the workshops and the rehabilitation potential of the instruction at the Spinal Unit. As so often was the case, the visit was an excuse for Guttmann to get his patients to show off their proficiency in sport.

There were some excellent demonstrations including basketball and badminton by the women. Dr Guttmann has also introduced archery as he

finds it excellent for developing shoulder muscles.[76]

Unfortunately, the provision of suitable employment for the patients fell far below that of the development of the women's shoulder muscles. The report was very critical, particularly where women were concerned, as there seemed to be no training provision for them, nor did there seem to be any administrative support for finding new homes.[77] There had been some early experiments with a group of male patients who were given training at a factory in Aylesbury. They had to be lifted into the back of a truck to be taken to and from work, and while the men had shown themselves to be keen workers, the experience was not repeated until better transport became available.[78] Transport issues were improved in October 1948 when the Ministry of Pensions announced that it would be providing cars and £45 a year for their maintenance to those ex-servicemen and women with 100% disability.[79] At a time when new cars for the general population were in short supply,[80] this gain for paraplegics was heralded as a significant step forward in recognising the necessity of reliable transport for those with severe disability. The provision of a car was a great improvement. Previously the war wounded had driven a three-wheeled motorised wheelchair whose unreliability was legendary, and the open top provided no protection from the weather. Women had to make do with these motorised wheelchairs for a

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[76]PRO LAB 18/469 Report by Norah Hill on her visit to Stoke Mandeville 25/10/1948.
[77] PRO LAB 18/469, The Report noted that 90% of hospital leavers found employment through their own efforts. Report by Norah Hill on her visit to Stoke Mandeville, 25/10/48.
[78] Scruton, *Stoke Mandeville*, (1998), p. 20.
[79] *The Cord*, Vol. 2, No. 2, (Winter, 1949), p. 7.
[80] Kenneth O. Morgan, *The People's Peace*, (London, 1999), p. 33.

longer period of time than men; many women were still driving them into the 1950s. One woman did receive a car in 1948, and the achievement was considered so important that the by-line 'Disabled Woman, Mrs E Eastman gets free car' was reported in the *Manchester Guardian*.[81]

Employment and transport were not the only areas in which paraplegic women were disadvantaged. Generally female spinal paralysed had a more difficult time than their male counterparts, as there were very few of them at the Spinal Unit of Stoke Mandeville, so when it came to their welfare, they had less influence than the men. Although homes had been available for the male paraplegic from 1946, there were no places for women to live with any degree of independence until 1949 when the Duchess of Gloucester House opened six places for women.[82] Provision of these few beds were obviously not enough as paraplegic women were still writing to *The Cord* in the 1950s complaining that living arrangements for women were unacceptable.

> The women pensioners in this hospital are certainly not catered for on an equal footing with the men. Those of us who have no home to go to are kept in hospital indefinitely because no accommodation is available.[83]

Stoke Mandeville and its affiliates were somewhat of an anomaly in the

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[81] *The Manchester Guardian*, (November 19, 1948).
[82] Guttmann, *Spinal Cord Injuries*, (1973), p. 12.
[83] *The Cord*, Vol. 4, No. 2, (Spring, 1951), p. 40.

experience of rehabilitation and resettlement. Whereas most centres such as Egham and Garston Manor used remedial exercises and games for the injured as a way to return them to fitness, gain confidence and assist people back to work in the overall pattern of rehabilitation, Stoke Mandeville focussed more on the medical aspects of recovery through sport and its Games, and less on the practical methods of employment. Although Guttmann remarked that he wanted 'to transform a severely disabled person into a tax payer,'[84] it meant more in terms of equality than it did in terms of procuring employment. Whilst there was no direct connection between prowess at sport and employment, games and activities did help the disabled person regain strength and control of their body, which lead toward greater confidence, independence and possibly employment. Stoke Mandeville's heavy focus on sport and less on job training may have been due to the fact that treatment for the spinal injured was still in its infancy, and doctors, particularly Guttmann were still experimenting with different types of therapy. As well as treatment, Guttmann experimented on his patients to learn more about paraplegia. He often put them into what they dubbed his 'sweat box' where he tested the affects of temperature regulation on them, continuing the work he had been doing prior to establishing the Spinal Unit.[85] Since 1946 he had conducted research on the effects of postural change on the cardio-vascular systems in paraplegics.[86] Later research on sexual reproduction revealed that

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[84] Scruton, *Stoke Mandeville: Road to the Paralympics*, (1998), p. 19.
[85] Scruton, Stoke Mandeville, (1998), p. 41.
[86] Put very simply these experiments were largely trying to find out why paraplegics would faint when moved from horizontal to vertical. Guttmann, *Textbook of Sport for the Disabled*, (1976), p. 41.

paralysed men were able to father children.[87] While not fulfilling its function as a rehabilitation centre in the accepted way of other institutions, many patients from Stoke Mandeville were eventually able to become tax payers.

Guttmann's unit produced results as previously very few patients had survived such serious injuring, never mind been able to participate in sport, so he was hailed as an example of innovative treatment in some quarters.[88] His patients were gradually able to find jobs through a combination of their own efforts and the assistance provided by the Disabled Persons (Employment) Act of 1944, so Stoke Mandeville pursued its course of sport for the paralysed with very few changes to its administration, or any loosening of Guttmann's control. As noted by Scruton,

> There was no question of whether the patient *wanted* to undertake sport – like work, Sir Ludwig introduced it into the dynamic treatment programme of spinal cord injuries with the same importance as that of bladder or skin care.[89]

It must also be borne in mind that Stoke Mandeville began to accept a few civilian patients after the war although the Unit provided mainly for those in the Forces. While those in the Services may have responded well to the tough

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[87] Guttmann, *Spinal Cord Injuries*, (1973), p. 641.
[88] There was no mention of Guttmann's early rehabilitative work in *The Lancet or the BMJ.*
[89] Scruton, 'Sir Ludwig Guttmann', *Paraplegia*, (May 1979), p. 52.

competitive regime of Stoke Mandeville, civilians may not have been so keen, so sport may have been as much of a trial as remedial exercises were to early generations of patients.

While physical exercise may have been a daily routine for certain groups of disabled people, for others it was at a poor stage of development or in some cases deemed injurious to the patient. Therapy for people with cerebral palsy was making some progress; remedial work undertaken by Mrs Collis in 1943 at Queen Mary's Hospital slowly began to filter through to the doctors after the war.[90] Eventually it would not be considered unusual for those with cerebral palsy to play games, but prior to this, they were generally kept in bed and deemed hopeless cases. In the pre-paralytic stage of poliomyelitis, exercise was deemed to be dangerous as it was thought more likely to cause severe paralysis and increase the likelihood of death.[91] The *British Medical Journal* suggested in 1949, 'sports meetings and special athletics contests should, if possible, be held outside the season for poliomyelitis'.[92] After the virus had passed through the system, physiotherapy was recommended to decrease the paralytic effect.[93]

Although the spinal paralysed were making their first forays into sport after the

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[90] Dean, *Three Steps Forward*, (1957), p. 36.
[91] *British Medical Journal*, (December 11, 1948), p. 1021 & (December 27, 1947) pp. 1023 & 1039. There was a considerable furore regarding an Australian nurse Miss Kenny who advocated remedial exercise and hot packs immediately following the onset of the illness. Medical practitioners did not approve of her methods. See also *British Medical Journal*, (August 6, 1949), p. 339.
[92] *British Medical Journal*, (March 19, 1949), p. 47.
[93] *British Medical Journal*, (April 10, 1948), p. 700.

war, those with sensory deprivations that had already been involved in recreational games continued that which the war had interrupted.[94] Although activities particularly designed for the spinal paralysed became an important feature of life at Stoke Mandeville, the Spinal Unit was not the only place in the world where sport was being adapted for the disabled. Goalball, a game designed for the blind made its debut in 1946 in both Germany and Austria, as a rehabilitative activity for veterans who had lost their sight during the war.[95] However, Goalball was not played in Britain at that time and the war blinded of St Dunstan's contented themselves with their Annual Regatta, walking races and outdoor sports days. As we saw in the previous chapter, there had been no official sporting events organised at St Dunstan's during the war. At its Queen Elizabeth Homes, the National Institute for the Blind used games, for example miniature golf, to assist in the rehabilitation of the civilian blind.[96] Schools for the blind, however, continued to hold sports days for their pupils, which were expanded after the war. Games continued to provide a social and competitive outlet, while not on the level of Stoke Mandeville, but their main purpose was to prepare the newly blind for adapted jobs and blind youngsters for work. The main function of the institutes of St Dunstan's, the NIB and blind schools was to provide employment, 'the most constructive help that can be given to the blind is

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[94] CMA SA/RBC C.8/9, Central Council of Physical Recreation, 'Facilities for Physical Recreation,' 1944.
[95] Clive Spencer, *Directory of Goalball*, (Worcester, 1986), p. 1.
[96] National Institute for the Blind, *Annual Report, 1945-1946*. p. 10.

to enable them to earn their own living'.[97]

While organised competitive sport was an important feature of Stoke Mandeville and its affiliated Homes, the range of activities for the blind appeared to be in decline. The walking races held all over the country continued to be popular amongst St Dunstaners and the results continued to be of a high standard, for instance, the winner of the six-mile victory walk in May finished in 61 minutes 23 seconds.[98] By 1949, however, the interest shown by the blind in the Annual Regatta had declined so much that it was cancelled 'owing to the lack of support'.[99] The Sports Days were also discontinued due to a low level of interest although the enthusiasm for walking races persisted. One reason for this was that walking competitions were open to all, and as blind people enjoyed a high degree of acceptance amongst the able-bodied, they were accepted into open events. Another mitigating factor may have been the relative age of blind people in the 1940s. The blind men from the First World War, where numbers were concentrated, were ageing, and perhaps not as keen to indulge in the more strenuous sports. Although the sporting interests of the blind ex-servicemen still continued through the post war period, they were never as vibrant as they had been immediately following the First World War. Social games organised by the NIB and sports for children at school continued. Sport as therapy was still relied on in the treatment of blindness to a certain extent, but with retraining and a job,

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[97] Ian Fraser, *Learning to be Blind: Britain Advances*, (London, 1943), p. 8.
[98] The winner was Arthur Morgan. 'A York Event', *St Dunstan's Review*, Vol. 31, No. 330, (July 1946), p. 3.
[99] *St Dunstan's Review*, Vol. 33, No. 363, (July 1949), p. 3.

many blind people did not have to rely on sport to show their capability, though they could still play games for their own recreation. Blind people did not have to prove their acceptability to the general public as unlike the spinal injured they were an established disabled group.

Rehabilitation was an important part of the way injuries were treated during and immediately after the Second World War, and this chapter has shown how that treatment was broadened to include disabled people who had previously been considered beyond help, namely those paralysed through spinal injury. At the Spinal Unit at Stoke Mandeville hospital from 1944, Guttmann experimented with remedial exercise and then games when he realised the therapeutic benefits to his patients. Sporting activities were adopted at Stoke Mandeville to such an extent that it gave rise to organised games in a competitive environment for the spinal paralysed from 1948. What made Stoke Mandeville special? It was partly due to the physical inactivity and damaged morale that resulted from paraplegia and the time that recovery took for the patients, but also due to Guttmann's single-minded pursuit of results as a medical practitioner. The cheerful and competitive atmosphere that was conveyed to the patients worked particularly well with its majority of young ex-servicemen. This dedication on the part of Guttmann to achieve recognition through sport for the spinal paralysed caused Stoke Mandeville to achieve worse results in other areas, namely in providing jobs for those who had been sufficiently rehabilitated to join the workforce. While this was not the original aim, sport seemed to take over as the primary purpose

of centre. In the eyes of the government, rehabilitation using whatever means whether it was sport, remedial exercises or weaving mats was supposed to result in the disabled person being fit enough to work. Sport was a means to an end, and not an end in itself. Although Stoke Mandeville actively pursued recognition for its sporting achievements within wider society, many other disabled groups such as blind and deaf people continued to participate in games and activities, without seeking publicity. During the 1950s, Guttmann would move sport for the paralysed further away from the merely therapeutic and build on the concept that sport and disability were not mutually exclusive concepts.

Chapter 5

Rehabilitating Disabled People: The State, Welfare and Employment Opportunity 1944-1960

At the formal opening of the Egham Industrial Rehabilitation Centre, the *Manchester Guardian* reported that Ernest Bevin, who attended the ceremony, remarked that after the First World War the welfare of many disabled was left to the care of voluntary associations. In the wake of the Second World War he stated that this time 'they had determined to make it a public responsibility.'[1] There can be no doubt, that many disabled people hoped that the post-war Labour government, elected on the promise of implementing the Beveridge Report, would be able to make radical change to provision for disabled people. This chapter will examine the legislation of that government that particularly affected disabled people. It will also distinguish between those pieces of general legislation, which emerged under the umbrella of the welfare state and benefited everybody, such as the establishment of the NHS, and those that were specifically designed to care for and advance the disabled within society.

Rehabilitation provision became was expanded by the government after the war to ensure that as many disabled people as possible were provided with the possibility a job. Following on the recommendations of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons,

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[1] *The Manchester Guardian*, (January 6, 1946).

legislation was drafted that would ensure that disabled people had more fair access to employment. The chapter will detail the influence of this and subsequent reports of this Committee throughout the late 1940s and 1950s. The expansion of the voluntary services will be juxtaposed alongside this new government responsibility for rehabilitation, and the chapter will reveal to what extent the two continued to depend on one another. Finally, the question as to whether or not this government involvement in rehabilitation and welfare ended the preference for the needs of disabled ex-servicemen will also be discussed.

As we have seen from the example of Stoke Mandeville and other operations, rehabilitation had become a vital part of the process for reducing residual disability, and ensuring that the disabled person would be able to lead as full a life as possible. Rehabilitation centres administered by the Ministry of Labour and National Service continued to provide treatment for a variety of disabilities. Indeed, new ones were opened. Farnham Park for example, was opened in 1947,[2] and Garston Manor in 1951.[3] Ernest Bevin's work on behalf of the industrial disabled had been successful, by 1945 there were rehabilitation centres established by the Ministry of Labour and National Service for miners, railway and dock workers.[4] Much of the early provision had been undertaken by the industrial companies themselves, but the government had established

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[2] Eagger A. Austin, 'The Work of Farnham Park', *Rehabilitation*, No. 8, (June 1953), p. 2.
[3] Both men and women attended these centres. Garston Manor provided ten out of its fifty-five beds for women. C.J.S. O'Malley, 'Garston Manor Rehabilitation Centre', No. 13, *Rehabilitation*, (Winter 1954/55), p. 11.
[4] PRO, FD1 68/10, Report by Harold Balme, Medical Officer in Charge of Rehabilitation, Ministry of Health, *Rehabilitation in the New Health Services*, 1945.

rehabilitation services and continued to take a more active role both during and after the war.[5] Similar to the rehabilitation centres set up in the Forces, these establishments focussed on the fitness of the patient and improved it with drill, exercise and sport as diversionary therapy. In addition to this, industrial training was provided in the hope that the newly rehabilitated would be able to find work. As well as these industrial training and rehabilitation centres, there was an increase in the number of hospitals that offered rehabilitation services. Hospitals of Stoke Mandeville's type, specialists units for rehabilitation, increased to 121 in 1946, from the 1943 total of 35.[6] In some cases, hospitals also combined with local industry as explained in the previous chapter, in order to provide some work for its patients. A soldier who had both feet amputated, for example, went to a rehabilitation camp after a stay at Roehampton to have foot prostheses made, for six weeks. He recalled being 'taken to various factories to see if we wanted to take up employment in these industries'.[7] It can be said that rehabilitation centres performed two functions of not only ensuring the minimisation of residual levels of disability through treatment, but also attempted to finish the rehabilitative process by helping to find work.

Britain became a leader in the field of rehabilitation demonstrated at international

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[5] Cooter, *Surgery and Society in Peace and War* (1993), p. 207.
[6] Overall, hospitals employing rehabilitation had increased to 333 in 1946 from 150 in 1943. Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, (1946).

[7] IWM Document Archives 92/10/1, O. Dover.

conferences where the methods of the Army, the RAF and companies such as Vauxhall Motors were demonstrated and discussed. One congress held by the Ministry of Education in 1948 on 'Physical Education, Recreation and Rehabilitation', for example, was attended by delegates from seventy-four countries who were studying British methods of rehabilitation.[8] The delegates were able to see rehabilitation methods at work as the RAF and the Army demonstrated the work of their centres.[9]

It was evident that the Forces gave rehabilitative methods a central role in their treatment of their injured, but what was the government stance? Obviously there was support in the establishment of centres by both the Ministries of Health and Labour, but was the government prepared to legislate for disabled people? As we have seen, special legislation was brought in during the war in order to use the untapped workforce of disabled people, and in 1943 the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons, or the Tomlinson Report was presented to parliament. This report was instrumental in informing government policy towards the disabled after the war, and provided in the main for the provision of jobs. Certain recommendations were brought forward, and these provided the basis of the Disabled Persons (Employment) Act

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[8] L.C. Williams, 'International Congress on Physical Education, Recreation and Rehabilitation, 1948', *Journal of Physical Education*, Vol. XL, No. 121, (November 1948), p. 102.
[9] Williams, 'International Congress on Physical Education, Recreation and Rehabilitation, 1948', *Journal of Physical Education*, Vol. XL, No. 121, (November 1948), p. 106.

of 1944, which will be discussed later in the chapter. After the initial report, a standing committee was established whose function was to ensure that the recommendations of the Tomlinson report were carried out and monitored, and publications were presented in 1946, 1949 and 1958 respectively.[10] Other non-government bodies were established in the interests of rehabilitation and its practise and expansion. In 1945 the British Council for Rehabilitation was set up by a group of member organisations to co-ordinate and promote both the practise and study of rehabilitation in Britain.[11]

In the main, rehabilitation's principal purpose was to ensure residual disability was reduced enough so that disabled people were better placed to find work. The interim scheme noted in chapter three, which assisted disabled people to find war work was replaced with a permanent piece of legislation in 1944. The Disabled Persons (Employment) Act was a breakthrough for disabled people as it was the first legislation which encompassed all disabled people of working age, regardless of their status of war or civilian. It came into affect in 1945, and focussed on the problem of finding work for disabled people, and made constructive suggestions for ensuring that this could be achieved. Both the reserved occupation list, the system of registration for all disabled people, and

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[10] The 1958 Report was known as the Piercy Report. Ministry of Labour and National Service, *Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons,* 1958.

[11] Member organisations included the British Legion, Central Council for the Care of Cripples, Empire Rheumatism Council, RNIB, RNID, Roffey Park Rehabilitation Centre, St Dunstan's, and the Chartered Society of Physiotherapy. *The Lancet*, (March 3, 1943), p. 285.

the quota system in which companies over a certain size had to provide a percentage of jobs for disabled people were recommendations of the Tomlinson Report which were adopted by the Act in 1945. A person was considered disabled if he or she was, 'on account of injury, disease or congenital deformity (is) substantially handicapped in getting or keeping suitable employment or work'.[12]

While the Act principally viewed disabled people in terms of their employability, it was generally seen as a positive step for by both disabled people and the government. Prior to the Act there had been very little legislation that recognised the needs of disabled people, and much of this had related to the educational needs of disabled children. For disabled people to be recognised for their value as employees in their own right was seen as a decisive move forward. Sir Ian Fraser, Chairman of St Dunstan's, approved of the assistance that the Act would provide for them.

> I see the possibility of the bill being used for the rebuilding of those who can be rebuilt and for the assistance of those who may have got past rebuilding.[13]

Watson-Jones stressed in *The Lancet* that the government was determined,

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[12] BRCS, Acc 1551/6 Pamphlet from the Ministry of Labour and National Service, September 1945.
[13] *The Guardian*, (February 5, 1944).

> To create the opportunity for employment of the disabled, not because the country is in peril but because the disabled are capable and worthy of employment.[14]

The Act purported to be applicable to all disabled people in Britain, and urged the disabled to register at their Local Labour Exchange. Registration had parameters however,

> The Register of Disabled, which is the total from which the quota is made up, is not the sum total of the disabled; it is the sum total of the disabled whose disability is a handicap to them in obtaining and retaining employment.[15]

The Act did not discriminate on the grounds of gender; both disabled women and children were to be helped by this legislation. When a disabled child over sixteen left his or her institution, both the Ministry of Education and the Ministry of Labour worked together to provide them with jobs. The Ministry of Education in Administrative memorandum No. 94 exhorted all schools to provide details of all disabled school leavers to them, so they might be registered in order that employment might be procured for them.[16] The parents of disabled children were

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[14] *The Lancet*, (April 15, 1944), p. 521.
[15] CMAC SA/RBC c.7/5, Speech by George Tomlinson, Parliamentary Secretary Ministry of Labour and National Service, Ex-Services Welfare Society Annual Medical Conference, 8 February 1944.
[16] CMAC SA/BMA, C.165, Ministry of Education, Administrative Memorandum No. 94, Choice of Employment for Handicapped Children, 8 October 1945.

also advised to register any children leaving special school, in order that the expertise of the Ministry of Labour could be used to find them work.[17] When a disabled child left school, the choice of career was to be made at a meeting with the child, parent, head teacher, juvenile employment officer, school medical officer and social worker.[18] If immediate work was unavailable or unsuitable, the young disabled person could be sent for instruction at one of the Vocational Training Centres run by the Ministry of Labour.

The Vocational Training Scheme was open to school leavers and disabled adults who had to undergo retraining for different types of work once they had undergone medical rehabilitation. Most of the instruction was conducted at Government training centres, of which there were 67 in 1946,[19] working closely with industry to ensure that trainees achieved the required standard. Three different types of training were provided, depending on the needs of the individual, which were the residential training centre, technical college and industrial training in employers' establishments. The more severely disabled adults attended residential centres such as Egham, which continued with its work after the war. These industrial rehabilitation units worked slowly using a variety of methods, including remedial exercises, physiotherapy, occupational therapy and finally light industrial work in order to prepare the patients for work, and were

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[17] CMAC SA/BMA C.165, Ministry of Education, 'Choice of Employment for Handicapped Children', Administrative Memorandum No. 94, 8 October, 1945.
[18] Clarke, *Disabled Citizens*, (London, 1951), p. 142.
[19] Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1946.

usually residential. Technical Colleges offered places for disabled school leavers to be trained for different occupations, as well as those who were less severely disabled. Finally, some employers made special arrangements with the Ministry of Labour for industrial training to be held on their premises, but these were operated on a small scale. As well as what might be termed 'outsourcing' of training services to private companies, the government also relied on the voluntary sector to provide rehabilitation services. The most severely disabled people were sent to one of three institutions, Queen Elizabeth College in Leatherhead, St Loyes at Exeter and the Sir John Priestman Hospital at Finchdale Abbey near Durham. These centres provided them with a longer period of training and rehabilitation than the normal duration of eight-week courses offered at government centres such as Egham. By 1948 these government centres had been reduced in number to 34, the reason being a shortage of buildings. The Ministry of Labour eventually overcame this problem by funding more places in the institutions funded by voluntary associations. In 1948, the number of places at the Queen Elizabeth College at Leatherhead was increased from 287 to 412.[20]

Courses of training at the government training centres varied widely as the trainees progressed through them. At the beginning, physical therapy, remedial gymnastics and games were played in the gymnasium that was installed in every training centre, but after the would-be workers regained strength, the focus of

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[20] Ministry of Labour and National Service, *Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1949.

their rehabilitation switched to employment. Even so, remedial exercises were still important and would often be part of an industrial trainees day, for example, apparatus would be fixed to his machine or seat which meant he could do his exercises while attending to his work.[21] Disabled people were trained in a variety of jobs, which included building work, shoe repairs and retail distribution.[22] Training in an increased number of occupations became available as the 1950s progressed and disabled people took up a variety of positions in the workplace.

When it came to training, disabled people were generally mixed together regardless of their disability. The one exception was the blind. Until the late 1940s, blind people had been cared for by local authorities as well as their own voluntary services.[23] But they had generally been exempt from other forms of training; such as joining government training schemes. Rehabilitation for blind people, which usually consisted of learning Braille, typing and learning to adjust to moving around, was nearly always done in a residential environment, as it was the general feeling that this was the only way that blind people would learn self confidence.[24] This rule was relaxed in 1946 when disabled ex-servicemen were allowed to join the Vocational Training Scheme.[25] The State took over the

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[21] W.L. Buxton, 'Industrial Rehabilitation units: A British Experiment', *International Labour Review*, Vol. 67, (1953), p. 541.
[22] In 1947 only disabled people were allowed to train for the building trade due to the restrictions on building. Ministry of Labour and National Service, *Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1949.
[23] St Dunstan's cared for the war disabled and the National Institute of the Blind looked after the welfare of civilians.
[24] *British Medical Journal*, (March 10, 195), p. 519.
[25] St Dunstan's continued to pay for the training. Ministry of Labour and National Service, *Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1949.

training of the civilian blind from the local authorities in 1948, but much of the function of placing blind people in work continued to be done by the RNIB throughout the 1950s.[26]

State provision of rehabilitation and training for blind people as well as other disabled groups increased the administrative burden of the Ministry of Labour and National Service. A by-product of the whole state organised rehabilitation process was the emergence of a new civil servant whose job was a direct result of the 1944 Act. The Ministry of Labour and National Service appointed specific staff who worked in Local Offices as Disablement Resettlement Officers. These people were specially trained to advise disabled people about training courses offered by the Ministry and to assist them to find work.[27] There were particular difficulties for the DRO's. For one thing they had no medical training, and they did not always understand the nature of particular disabilities. Indeed, their training of three days duration was clearly insufficient. By 1948 the Ministry had tried to improve the service offered by appointing District Disablement Resettlement Officers to oversee their training and hospitals established Medical Interviewing Committees to advise the DRO's on the medical aspects of their clients.[28] Although the system was reasonably successful, and the DRO's could appeal to the committee whenever there was difficulty placing a disabled person

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[26] Selwyn Selwyn-Clarke, 'The British Rehabilitation Service', *Rehabilitation*, No. 16, (Winter 1955/6), p. 22.
[27] Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1946.
[28] Ministry of Labour and National Service, *Second Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1949.

in a job, there were still concerns about the levels of expertise required of the Officers. By 1956 the training period for an Officer was still only three to four days, and the Standing Committee that advised on rehabilitation recommended that this period be extended to four weeks.[29]

The fight to secure regular work for the disabled was facilitated through three different processes. Registration by the disabled person was the first step, which was usually organised at the local Labour Exchange. Secondly, a quota system was set which required every employer with over twenty staff to employ a fixed percentage of disabled workers. Originally this was set at two percent, but in 1946 it was increased to three percent.[30] However, employers were not forced to adhere to this rule. If an employer had insufficient numbers of disabled, he was just told to replace any employee that left with a disabled person.[31] Thirdly, the designated employment scheme reserved certain occupations specifically for disabled people. The choice was not wide, as there was only two such occupations namely, lift operator and car park attendant.

Although all disabled people were supposed to benefit from this Act, there was an interesting twist that only came about after internal pressure was applied after it was first drafted. Bevin had pushed for those people disabled by the war to be

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[29] Ministry of Labour and National Service, *Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1958.
[30] CMAC SA/BMA C.165, Statutory Rules and Orders and Statutory instruments Revised – Disabled Persons (Employment) to December 31, 1948.
[31] Clarke, *Disabled Citizens* (1951), p. 162.

given no preference as we saw in chapter three, and in fact the Tomlinson Report had specifically noted that being disabled in the war may not be a barrier to employment as it was for civilian disabled people.[32] However, pressure was applied in parliament by a group of Members, who included Sir Ian Fraser and Sir Brunel Cohen, to ensure that the Act gave preference to those injured in the war.[33] Women were also advised to register, and if they had served in the Armed Forces they were also given preferential treatment. Two special schemes were established to benefit disabled men and women from the Services. Firstly, there was a system of grants in order for a disabled person to set himself or herself up in a small business.[34] There was also a system to provide higher education to those recently disabled ex-servicemen and women through the Further Education and Training Scheme, which was organised by the Board of Education.[35] Not only were those disabled while in the Forces given preference but,

> An ex-Service man who becomes disabled after discharge from Service has the same right to preference as the ex-Service man who was disabled

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[32] The report also suggested that war pensioners should not have the right to automatically register for work. *Report of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1943.
[33] Wootton, *The Official History of the British Legion*, (1956), p. 269.
[34] BRCS, Acc 1551/6, Pamphlet from the Ministry of Labour and National Service, September 1945.
[35] Ministry of Labour and National Service, *Report on the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1946.

during Service.[36]

There were other problems within the State organisation. There was no system to ensure that employers kept to their quotas of disabled people working for them. Moreover the reserved occupations were described as unchallenging by disabled people. Sometimes, the very people who the system purported to help were unable to use facilities ostensibly provided for them, for example only three residential centres for training would accept disabled people in wheelchairs.[37]

Despite the working of the system, which was clearly skewed towards the needs of the war wounded, and driven by demands of the post war employment boom, many disabled people still registered. Those who were not registered did not have access to any of the vocational or industrial training programmes, so it was important to do so. In December 1945 the roll opened with 150,000 names and by March 1946 this had increased to 225,000.[38] Although the register did not amount to the 1-1.5 million names predicted by Harold Balme in the *British Medical Journal*,[39] the numbers did peak in 1950 at 900,000.[40]

Work was still the best way that disabled people could publicly redeem and

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[36] BRCA Acc 1551/6, Pamphlet from the Ministry of Labour and National Service, September 1945.
[37] These were St Loyes in Exeter, the Queen Elizabeth College, Leatherhead and Portland Training College, Mansfield. PRO BX4/30, *National Survey of Paraplegic and Seriously Disabled Miners*, (1955).
[38] Barry Turner & Tony Rennell, *When Daddy Came Home*, (Kent, 1995), p. 10.
[39] *British Medical Journal*, (February 9 1946), p. 215.
[40] Alfred Morris & Arthur Butler, *No Feet to Drag*, (London, 1972), p. 56.

rehabilitate themselves. It was generally believed by the public if a disabled person could work, and thereby pay their own way, and this manifested itself in exhibitions of disabled people's work and shops such as. One in particular was held for one month in London, entitled 'And So To Work' which detailed different government department's work on behalf of disabled people. For example, the Ministry of Health displayed its social service department and the type of treatment and industrial placement at Pinderfields Hospital, and a curative workshop.[41] Products made by disabled people that were for sale. The government was not the only interested party when it came to providing employment for disabled people. The public was also interested in jobs for the disabled, and suggestions were made as to what work they should do, for instance a letter to *The Times* proposed that disabled people be given jobs at the football pools.[42]

Those people whose disability precluded them from finding work within the open job market were not excluded from the reforms. Recommendations by the Tomlinson Report saw a factory system for severely disabled people set up in 1945, as the Disabled Persons Employment Corporation, establishing 'British Factories' later renamed Remploy. These institutions provided jobs for severely disabled people who, despite rehabilitation, found it difficult to find work. The first factory was established in 1946, and others followed, so that by 1948 there were 25 in operation, making a wide range of products from industrial leatherwork to

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[41] PEA 1/8, Executive Committee Minutes, (17 January 1947).
[42] Letter to the Editor, *The Times*, (October 17, 1947).

cardboard boxes.[43] Sites to set up factories were difficult to find and both the shortage of material and the ban on industrial building slowed the expansion of Remploy, but special permission was received to continue building some factories so by 1953 there were ninety factories employing 6,000 disabled people.[44] Generally, Remploy factories did not offer positions to the blind as they had a much more established system of workshops and government assistance.[45] Instead, Remploy concentrated on providing employment for those with pulmonary tuberculosis, congenital deformities, heart and lung disease and epilepsy.[46] The project was beset by problems, including higher costs because buildings had to be erected, high absenteeism due to the health of the severely disabled, and difficulties with transport even though Remploy located its factories in areas where there were significant numbers of disabled people.[47] By 1952, there was a call for many more Remploy factories, but considering that the Exchequer had to fund this loss making project,[48] the government demurred whether or not it would be better spent to concentrate more on rehabilitating the disabled to enable them to work in open industry.[49] Remploy continued to operate at a loss throughout the 1950s despite favourable government contracts, similar to those offered to employers participating in the Kings National Roll after

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[43] Ministry of Labour and National Service, *Second Report on the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, (1949), p. 15.
[44] 'The Work of Remploy', *Rehabilitation*, 9, (1953), p. 9.
[45] The National Institute of the Blind's workshop made a host of products featuring their logo, including a souvenir for the Festival of Britain, which was soap in a plastic container. *The New Beacon*, Vol. 35, No. 413, (May 1951), p.107.
[46] J.L. Edwards, 'Remploy', *International Labour Review*, (1958), p. 152.
[47] Edwards, 'Remploy', *International Labour Review*, (1958), p. 151.
[48] In 1952 Remploy had a recorded loss of £2,380,399. 'The Work of Remploy', *Rehabilitation*, 9, (1953), p. 9.
[49] Beveridge, *Voluntary Action*, (1948), p. 252.

the First World War.[50] Providing sheltered workshop employment was a costly exercise.

With this problem in mind money, state money was also being offered to help private efforts. At the same time as it was opening Remploy factories, the government was also providing funds under a Scheme of Grants to Voluntary Undertakings, that is to those private groups or individuals who provided sheltered workshop employment for disabled people. Numbers were small, with only 700 disabled people given work under 25 government grants in 1949.[51] Unlike Remploy, these businesses were run at a profit and like the Michael Works, were not willing to accept a lower standard of production from its workers.[52] Businesses that used disabled workers could be more profitable as it also meant that employers did not have to pay union rates.[53] Other workshops were established at different Homes for disabled ex-servicemen, and these were usually well supported by voluntary services. The Lord Roberts Memorial Workshops assisted the Star and Garter Home to start a workshop for clock repair and assembly in 1946.[54] The enterprise grew, and in 1950 two new workshops were completed as a result of a visit from Lord Nuffield.[55]

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[50] Ministry of Labour and National Service, *Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1958.
[51] Ministry of Labour and National Service, *Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1949.
[52] New employees at Michael Works were given three weeks to reach the accepted standard. Failure to do so meant instant dismissal. Clarke, *Disabled Citizens*, (1951), p. 163.
[53] Rates for disabled workers were set at 75% of those of the able-bodied.
[54] *Star and Garter Annual Report*, (1947), p. 9.
[55] The workshops were finally finished in 1950. *Star and Garter Annual Report 1950*, p. 9.

As we have seen, getting disabled people to work was important for two different reasons. The severe labour shortage made the employment of disabled people necessary, as there simply were not enough people for the jobs available. In the same way that the disabled had taken positions that allowed the more active to fight the war, they were still needed when Britain began rebuilding. There were other considerations that were merely economic. It was far better to have the disabled pay tax and produce goods and services[56] than have reduced numbers of productive members of society. Britain's economy was in a perilous position after the war, the British welfare state was becoming a reality but the ideal of welfare for all did not mean that the government wished to be burdened with the welfare payments for thousands of disabled people. As Correlli Barnett pointed out in *Audit of War,* Britain had

> A ruined export trade, heavily in debt to its bankers (the Sterling Area Commonwealth countries and the United States), and with huge inescapable continuing burdens with regard to the war with Japan.[57]

The National Insurance Act of 1946 provided a system of insurance for all those registered and able to contribute, which included disabled people. For those who could not work, referred to as the chronic sick, (although their disabilities were not always caused by illness) other means of support were offered. This Act

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[56] Buxton, 'Industrial Rehabilitation Units', *International Labour Review*, Vol. 67, (1953), p. 546.
[57] Correlli Barnett, *Audit of War*, (London, 1986), p. 37.

provided disabled people with a subsistence income.[58] It also allowed the Blind Persons Act of 1920 to be extended to include the severely physically disabled as well as the deaf.[59] A wide range of provision was covered by the Act; for instance Section 29 of the Act called for recreational facilities to be provided.[60]

The National Health Service provided the British with medical care and other health services provided free at the point of delivery. What did this new development mean for the disabled population? The establishment of the NHS meant that the disabled had to equipment and aids that previously they may not have been able to afford. Its provisions also covered a wide range of disabled groups. Prior to this, disabled people had been forced to pay or go without. In May 1946 The Employment and Pensions Department of the British Legion had written to the Secretary of the British Medical Association to protest at doctors charging 1/6 to sign the certificate which proved that an ex-serviceman could register as disabled.[61] Under the new system, however, disabled people were not penalised for their disability. Children no longer had to go without artificial limbs until they were fully-grown, and wheelchairs and sticks were provided to help those who had difficulty walking. There was a significant increase in the provision of glasses and hearing aids as disabled people tried to minimise the effects of their disability.[62] For deaf people the Medresco NHS hearing aid was

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[58] Owen, *English Philanthropy*, (1965), p. 532.
[59] Central Office of Information, *Rehabilitation and Care of the Disabled in Britain*, (London, 1962), p. 28.
[60] Mary G. Thomas, *Party Games for the Blind*, (London, 1970), p. 1.
[61] CMA SA/BMA C.165, Letter from R.H.W Davidson, Employment and Pensions Department, British Legion to the Secretary of the British Medical Association, 17 May 1946.
[62] Virginia Berridge, *Health and Society in Britain Since 1939*, (Cambridge, 1999), p. 24.

provided free, and for some a hearing aid could make a lot of difference. Deaf people were also saved the costly indignity of being swindled by dishonest salesman who would pray on their desperation to hear, and sell them equipment that did not offer the miracle cure that they had been expecting. Disabled people were provided with free treatments like physiotherapy on the NHS. Peggy Tasker recalled, 'the NHS changed our lives.'[63]

Another benefit of the NHS was that it was instrumental in providing services for the civilian disabled, thereby closing the gap between their services and those to which the war disabled were entitled. It must be borne in mind that benefits, including cars and in many cases hospital and residential care were provided to the war disabled through the Ministry of Pensions. The Ministry of Health provided an equivalent for the civilian, similarly disabled, by issuing the three-wheeled Invacar and the AC car, which were similar to a covered version of the early motor tricycles. Money was provided for their maintenance as well as £5 for fuel per year. The little 'cars' were also insured for free.[64] While many disabled people were satisfied at last to have a form of transport, both the AC and the Invacar had several drawbacks, which made them inferior to the four-seater cars provided to the ex-servicemen. The 'cars' were unreliable, unheated and as they were only limited to one passenger, not useful for family outings.[65]

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[63] Interview with Peggy Tasker, April 1998.
[64] The petrol grant ended in 1972. Morris and Butler, *No Feet to Drag*, (1972), p. 78.
[65] The police would pull over any driver of an Invacar who was carrying a passenger. Some disabled people found a way to avoid confrontations with the police, for instance, Len Tasker's his wife Peggy would sit on the floor of his Invacar so that the police would not see her. Interview with Len and Peggy Tasker, April 1998.

The cars were also very light and would often overturn in a gust of wind. A fellow student of polio sufferer Jim Porteous, who had an Invacar at sixteen, interrupted his chemistry class to say, 'Sir, I'm terrible sorry, but Porteous's car has blown over'.[66] Not all incidences were as amusing or as harmless. One paraplegic lay upside down in a ditch for fourteen hours before anyone found him after his Invacar tipped over in a strong wind. Other complaints included the time that repairs took in nominated garages, sometimes months.[67] Despite the problems, the Invacar continued to be provided for disabled people and by 1959, there were approximately 11,300 NHS state owned motor tricycles.[68] In 1960 there were debates in the House of Commons as to whether four-seater cars should be supplied to all severely disabled people such as paraplegics, and not just limited to the war disabled. Sir Ian Fraser, champion of the wounded ex-servicemen argued against this suggestion and the Minister of Health, Derek Walker-Smith reminded parliament that 'a question of costs had to be in their mind'.[69] The civilian disabled continued to be provided with Invacars and if they wanted another type of transport had to pay for them.

By 1951 the National Health Service was administratively robust and large enough to take over many of the rehabilitation centres that had previously been under the control of a variety of agencies and government departments, for

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[66] Tony Gould, *A Summer Plague: Polio and its survivors*, (New Haven, 1995), p. 241.
[67] PRO BX 4/30, *National Survey of Paraplegic and Seriously Disabled Miners*, (1955).
[68] BRCS JCM/1/6/3/42 352, Report: *History of Motor Propelled Tricycles.*
[69] *The Manchester Guardian*, July 1 1960.

instance the Miners Rehabilitation Service.[70] This process was gradual. The hospitals and centres controlled by the Ministry of Pensions were not transferred to the NHS until 1953 when Pensions were amalgamated with National Insurance. Even when the Ministry of Health took over their care, the war pensioners still retained some of the preferential treatment they had enjoyed with the old Ministry.

> All other hospitals in the National Health Service were asked in 1953 to give priority of admission to war pensioners for treatment of their accepted war disabilities, subject only to the needs of emergency and other urgent cases.[71]

This parsimony by the post Attlee government extended to the supply of appliances, such as adapted cutlery and walking frames for the elderly. Neither the hospitals nor the government wanted to spend money on these items. A suggestion was made that either the disabled person pay for it themselves, or apply to the Local Welfare Fund.[72]

Although the State played an increasing role in the lives of disabled people during and after the Second World War through the NHS, National Assistance

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[70] Central Office of Information, *Rehabilitation and Care of the Disabled in Britain*, 1962.p.10.
[71] Central Office of Information, *Rehabilitation and Care of the Disabled in Britain*, 1962.p.12. [71] PRO MH 99/83, Report on Appliances, 1958-62, London.

[72] PRO MH 99/83, Report on Appliances, 1958-62, London.

and employment, there remained plenty of work for voluntary agencies.

> The voluntary sector grew in the wake of both the limitations and the achievements of the welfare state for it was the achievements that revealed the limitations.[73]

According to the 1952 Nathan Committee on Charity, there were 110,000 charitable trusts in Great Britain in 1950.[74] While not all of these represented disabled people, there were many voluntary associations that did so and during the 1950s many new organisations were formed. During the late 1940s and throughout the 1950s the work of disabled support groups began to expand and to specialise, focussing on a single disability. Although older disabled groups such as blind people were represented by about 100 different organisations,[75] new bodies, which represented a myriad of disabled groups and specific interests, were establishing themselves. Two organisations representing those with cerebral palsy were formed during this period. The British Council for the Welfare of Spastics was formed in 1946[76] probably due to the work that was being done in the field at that time, and was followed in 1952 the Spastics

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[73] G. Finlayson, *Citizen, State and Social Welfare in Britain*, (Oxford, 1994), p. 317.
[74] F.K. Prochaska, 'Philanthropy', in F.M.L. Thompson (ed.), *Cambridge Social History of Britain, 1750-1950, Volume II*, (Cambridge, 1990), p. 358.
[75] Private sources paid approximately £1.5 million per year toward the blind and the government spent about £3 million. Beveridge, *Voluntary Action*, (1948), p. 246.
[76] The two did not amalgamate until 1963. Richard Dimbleby, *Every Eight Hours*, (London, 1964), p. 32.

Society.[77] This second group was established when the parents of children with the condition felt that the British Council for the Welfare of Spastics was not doing a good enough job of representing those with cerebral palsy.[78] The Multiple Sclerosis Society was established in 1953, and the Muscular Dystrophy Group was formed in 1954.[79] The British Epilepsy Association, representing one of the less understood of disabilities was established in 1951.[80] Other associations aimed to represent a wider cross section of disabled people were established during the 1960s, for example, the St Giles Housing Society was formed in 1960 to provide housing and other amenities for those of limited means in the London and Home Counties.[81] Other groups with a shared interest also appeared after the war. The Invalid Tricycle Association was formed in 1948,[82] after numbers of AC and Invacars had started to be provided for the civilian disabled. More established organisations for disabled people such as the Central Council for the Care of Cripples, co-ordinated many of the organisations that worked for the welfare of disabled people, and took up issues relating to a wide section of the disabled community.[83] During the 1950s, for instance, the Council became interested in access to buildings for disabled people. The Red Cross continued to provide comforts to the disabled, which took a variety of

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[77] Morris & Butler, *No Feet to Drag*, (1972), p. 42.
[78] PRO ED 50/565, Special Services General File: Provision for Spastic Children, 1954-1955.
[79] Central Office of Information, Rehabilitation and Care of the Disabled in Britain, (1962), p. 28.
[80] Central Office of Information, Rehabilitation and Care of the Disabled in Britain, (1962), p. 28.
[81] *A Record of Fifty Years Service*, (1969), p. 51.
[82] Disabled Drivers Motor Club, *75th Anniversary Celebration* (Northamptonshire, 1997), p. 21.
[83] PRO MH 55/2242, Central Council for the Care of Cripples Development Sub-Committee, 1957-1958.

forms, from cigarettes to invalid chairs.[84] Other public organisation also assisted disabled people including the BBC, which continued its charity work on behalf of disabled groups which often featured on the BBC's Weeks Good Cause Appeal. The British Council of Rehabilitation, for example, received £1000 in donations when their appeal was broadcast on June 25, 1950.[85]

As well as organisations that served the interest of single disabled groups, such as the RNIB and ones that looked after broader issues such as the Central Council, other voluntary associations provided very specific services for disabled people. Part of the reason for the expansion of this type of association was that at last the State was providing a system of basic care, so organisation could expand their range of activities and not have to deal only with disabled people's subsistence. There are suggestions that pleasure became a national obsession in the late 1940s due to the privations of war.[86] During the 1950s, there was also an increasing level of interest during the 1950s in holidays for disabled people, and the Central Council for the Care of Cripples attempted to find ways to meet it. The Red Cross also organised holidays for the disabled.[87] Less centrally funded associations did the same including the National Cripples Journal, which bought a holiday home for people with polio who required an iron lung. Some individuals organised holidays for disabled people, such as Joan Brander, who

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[84] P.G. Cambray and G.C.B. Briggs, *Red Cross and St John War History*, (London, 1949), p. 132-133.
[85] *Rehabilitation*, No. 1 (January 1951), .p.30.
[86] James Walvin, *Leisure and Society 1930-1950*, (London, 1978), p. 149.
[87] British Red Cross Society, *The Ceaseless Challenge; Souvenir of the Red Cross Centenary*, p. 79.

was given a grant of £1200 from the *People* newspaper to establish the Winged Fellowship Trust in order to take disabled people to Grange Farm, Essex.[88] Another location opened in Bexhill by the Countess of Westmoreland and catered for twenty children at a time with cerebral palsy.[89] The Guild of St Giles and the Woodlarks campsite also provided opportunities for disabled people to enjoy themselves.

Day trips out, often sponsored by ex-servicemen's associations were still common in the 1950s. Many disabled ex-servicemen attended the Festival of Britain in 1951, and in some cases special arrangements were made for them to go. Other ex-servicemen's associations such as the British Legion ensured that the war wounded had holidays, and institutions such as Stoke Mandeville provided the means for some of its patients to have a holiday at the Duchess of Gloucester House, and later at Chailey.

Ex-servicemen's associations continued to represent their member's interests.[90] The British Legion was the most powerful ex-service association, with a membership that stood at over one million between 1946 and 1950.[91] During the war, they had managed to rid the statute books of the seven-year rule, which previously had prevented those with a disability from claiming a pension if their

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[88] Morris & Butler, *No Feet to Drag*, (1972), p. 103.
[89] Dimbleby, *Every Eight Hours*, (1964), p. 44.
[90] The Kings National Roll was still in operation in 1956 for those who had been disabled in the First World War. *Report of the Committee of Inquiry on the Rehabilitation Training and Resettlement of Disabled Persons*, 1956.p.64.
[91] Wootton, *History of the British Legion*, (1956), p. 305.

disability had manifested itself after that prescribed period of time.[92] Their influence within parliament remained strong, with MP's like Sir Ian Fraser and Sir Brunel Cohen, arguing in favour of preferential employment for the war disabled and against any disabled group other than the war wounded having four-seater cars, as we saw earlier in this chapter.[93] Direct action as well as parliamentary lobbying became a tool of the disabled ex-servicemen. BLESMA took action in 1951 when 800 of its members conducted a Silent Reproach March to Downing Street in protest that pensions had dropped below the cost of living.[94] In 1956 it used the same method to demand increased pensions for the elderly war disabled in order that their standard of care did not diminish in old age.[95] This action was very successful as the basic rate of pensions for disabled ex-servicemen rose three times between 1948 and 1957.[96]

Although the special interest groups that represented the war wounded kept their organisations in the public eye, money often ran short. The British Legion's Poppy Day, which from 1943 was grossing nearly one million pounds a year, provided St Dunstan's, British Legion Homes and other war disabled charities with varying amounts of money each year.[97] Other charities such as the British Red Cross provided funds for repairs and other capital expenditure such as buildings. However, despite all of this assistance, many establishments such as

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[92] This was changed in 1943. Brown, *Red for Remembrance*, (1971), p. 101.
[93] Wootton, *The Politics of Influence*, (1963), p. 243.
[94] Ryde, *Out on a Limb*, (1982), p. 49.
[95] PRO, PIN 59/71, Disablement Pensions, 1956.
[96] Wootton, *The Politics of Influence*, (1963), p. 239.
[97] Wootton, *History of the British Legion*, (1956), p. 317.

Homes for the war wounded ran short of money. The government did supply funds for some of them; for example, it provided £21,000 towards the running of the Star and Garter Home in 1947.[98] Since the actual running costs were £71,000 per year, voluntary services and private charity still had a fundamental role to play in its fiscal support. The Star and Garter Home did not rely merely on charitable donations to make up its shortfall, but offered families bed endowments, as memorials to those killed in the Second World War.[99] Sports days or exhibitions of disabled ex-servicemen's work would usually carry a small entrance fee the total of which would go to the home presenting the event.

The last report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons also known as the Piercy Committee, after its Chairman, Lord Piercy, was probably the most interesting and warrants some analysis. The Committee was appointed in 1953 and its purpose was:

> To review in all its aspects the existing provision for the rehabilitation, training and resettlement of disabled persons, full regard being had to the need for the utmost economy in the Government's financial contribution, and to make recommendations.[100]

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[98] *Star and Garter Annual Report 1947.*
[99] A donation of £1500 endowed a bed in perpetuity. *Star and Garter Annual Report 1946.*
[100] PRO MH 55/2158 Statement in Parliament on the establishment of the Piercy Committee, DP 1096/1952.

What was interesting about the final report was that for the first time voluntary agencies asked to be part of the committee and have some say over how the State ran its rehabilitation and training service. Indeed, voluntary services played an important role in provision for disabled people and as we saw earlier in the chapter, they were expanding to represent the interests of all disabled groups.

Before the committee was even established, the government was warning that funding would not be available for sweeping improvements for disabled people.[101] One of the most telling indications of what the government would do when the report came out was the way in which the Committee was selected. There was much discussion prior to its establishment, as to how it would be staffed. It was agreed that there would be no voluntary services represented on the Committee, and only government officials would be present because,

> ...the enormous number of bodies that would think they ought to be represented...(they) would be only too disposed to grind its own axe..that any report emanating from a body of this kind would almost certainly be full of the most ambitious and expensive projects embarrassing to Ministers and the Chancellor of the Exchequer.[102]

Chancellor of the Exchequer R. A Butler wrote to the Minister of Labour Sir

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[101] For an overview see Kevin Jeffreys, *Retreat From New Jerusalem: British Politics, 1951-64* (Basingstoke, 1997), chapter 6.
[102] PRO MH 55/2158, Minute Sheet PSO 209, 15 November 1952.

Walter Monckton in February 1953 and described how the inclusion of voluntary bodies on the Committee was unacceptable because undoubtedly they would insist on spending increases.

> Almost inevitably the Committee would make recommendations involving increased expenditure and this is not a result which in present circumstances I can contemplate.[103]

Despite their requests, representatives from voluntary agencies were not allowed on the Committee, nor were they consulted about provision. The Committee sent memos to regional hospital boards inquiring about the facilities and staffing arrangements that they provided for rehabilitation of disabled people[104] and bypassed the voluntary agencies. When the report was published, although it praised work done by voluntary agencies on behalf of disabled people, the government also reminded them that the future of voluntary work lay in 'personal interest and care', which the government did not provide.[105]

The Committee also did not see any need to increase investment in training and rehabilitation services for disabled people, despite making 43 recommendations

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[103] PRO MH 55/2158, Letter to Walter Monckton from R. A Butler, 14 February 1953.
[104] PRO MH 55/2158, Memo to all Regional Hospital Boards from Tom Nicole, Joint Secretary Ministry of Health.

[105] Ministry of Labour and National Service, *Third Report of the Standing Committee on the Rehabilitation and Resettlement of Disabled Persons*, 1958.

throughout the report. The Committee justified its economic restraint with the following statement:

> It is, moreover, dangerous to assume that more effective services can be brought about solely, or even mainly, by increased expenditure, because some of the best work in the rehabilitation field has been done by relying on the capacity to inspire the disabled to help themselves and the intelligent adaptation of available materials.[106]

Naturally, the reaction from the many agencies that looked after the interests of disabled people was one of disappointment, as few changes would result from the committee's recommendations, especially if no money was to be spent. While the government was prepared to lean heavily on voluntary agencies for support, there was no such reciprocal arrangement when it came to voluntary services gaining support in fiscal terms. The request to the committee to be allowed representation was a testament to the voluntary agencies newly found strength in numbers and expertise. After all, many of them had been providing care for disabled people for many years before that job had been partially taken over by the State. In the following decade, the government would finally listen to the demands of a voluntary association, but until then their requests to have

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[106] *Report of the Committee of Inquiry on the Rehabilitation Training and Resettlement of Disabled Persons*, 1956.

some sort of representation on these important government committees were rejected.

It is impossible to write about disablement in the twentieth century without understanding the relevance, and impact of the establishment of the welfare state. The benefit for disabled people was twofold. Not only did the blanket legislation such as the establishment of the NHS benefit them enormously, but there was specific legislation drafted with them in mind for the first time. The Disabled Persons (Employment) Act of 1944 and the National Assistance Act gave disabled people advantages that they had not known previously. The State's responsibility for much of the rehabilitation provision ensured that disabled people progressed through the system, and the Ministry of Labour and National Service would provide jobs for all disabled people, even if they were severely disabled, and not leave them to the vagaries of the open job market.

This chapter has shown that the development of the welfare state had a profound effect on disabled people. However, the legislation was far from perfect, and still favoured, whether in the workplace, in education or in rehabilitative centres, certain disabled groups over others. We have also shown that the very conception of legislation for the disabled was not altruistic; it was designed to keep the total cost of caring for disabled people as low as possible by returning the maximum number to the workplace where they could contribute productively to the nation's economy. Although the state's role with respect to disabled

people increases after the Second World War, it never becomes the sole agency that assists them. The role of charitable and voluntary organisations continued to be of the utmost importance, and even in the heady days of the evolving welfare state their role should not be underestimated.

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Chapter 6
Growth and Decline: Sport and Physical Recreation 1950-1960

Sport and leisure activities witnessed a period of steady growth during the 1950s. Increasing amounts of free time and disposable income meant that many young people could actively participate in leisure activities, or else travel to football grounds and other venues to watch professional sport. In the same period disabled sport underwent a steady but uneven growth. This chapter will examine the nature of this growth, and explain that while some disabled groups continued to actively embrace sport as a central part of their lives, for others it ceased to be so important. In making such an argument, a basic tenet of the thesis will be reinforced: not all disabled groups used sport in the same way and neither did they all embrace it with the same enthusiasm.

The 1950s heralded new organisational innovations for disabled sport. While these were rather crude at first, such innovations laid the groundwork for what would become the basis of a formalised sporting structure. It was the 1950s and 1960s which, it will be argued, transformed sport for the disabled from an activity that was primarily aimed at rehabilitating the individual, into one that functioned on an organisational and competitive level for its own ends. As the development of the formalised structure was slow, and not all branches of disabled sport were located under its umbrella, it is evident that charity was still a means of support for the disabled and in this sport was no exception. The chapter demonstrates the dichotomy that exists between different groups of disabled people, some of whom are actively embracing competitive and organised sport, while others are continuing with activities that are small scale

and predominantly concerned with rehabilitation. Despite the advance of organised disabled sport during this period, physical training remained an important part of the process of rehabilitation and had its basis in a medical rehabilitative model.

In addition to the sporting detail, we will outline some of the more general aspects of disabled history during this period. The numbers of disabled people continued to increase, not least because there were large epidemics of poliomyelitis in the late 1940s and 1950,[1] and for those with residual disability, therapy was long and involved. Road accidents also increased in 1950, as petrol rationing was abolished, with 48,652 people seriously injured in that one year alone.[2] So, while disabled people pursued sporting goals, their numbers were constantly being refreshed. For those newly disabled, treatments were better than they had ever been, and the support networks that were in place offered an easier transition from hospital patient back into the working and social world. In this process, sport and physical exercise were important: they offered an essential part of rehabilitation once an injury had been suffered, and then subsequently became, if desired, an aspect of an active, competitive sporting life.

During the 1950s, Stoke Mandeville dominated disabled sport and grew exponentially. Part of the reason for this growth and publicity was the ongoing work of Ludwig Guttmann, who constantly and tirelessly promoted 'his'

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[1] *British Medical Journal*, (June 30, 1951), p. 1511.
[2] *British Medical Journal*, (March 10, 1951), p. 537.

athletes. Although sport was played by amputees and by the blind and deaf, it was Stoke Mandeville that embarked on establishing an organised form of disabled sport. For the blind and amputees, the umbrella of Stoke Mandeville's organising expertise would not be offered until the 1960s. Stoke Mandeville was busy establishing itself as a centre promoting the interest of the spinally injured, before it would extend to helping others. The culmination of all the hard work of Guttmann and the disabled athletes came in Rome when the first International Stoke Mandeville Games for the Paralysed were staged. These were held at many of the Olympic venues that the able-bodied had used earlier in that year.

As we saw in chapter four, in 1950, the awareness of the general public of Stoke Mandeville and its paraplegic sportsmen and women was raised by their participation at the Festival of Sport. Although this one appearance hardly brought disabled sport to the front of the public's mind, it was an activity that might enable the public to better relate to disabled people, especially the paralysed in wheelchairs in which: '...to 'belong' to the community one has to be a competent participator in some activity which the community regards highly'.[3]

There would be little recognition for pulley exercises or drill for the paralysed, but the general public might be more interested in the disabled if their public displays featured sporting activity. Although the Games at Stoke Mandeville were generally a local affair, the 1950s opened up further opportunities for the

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[3] Kershaw, *Handicapped Children*, (1961), p. 37.

promotion of paraplegic sport which Guttmann was quick to exploit. There was little interest in or interaction with other disabled groups at this time, and it was to the able-bodied that Stoke Mandeville promoted itself. Generally, this was always in order to put forward their sporting accomplishments, for example, when the Star and Garter Home[4] was included in a show called 'A Trip Up the River', with Richard Dimbleby, the highlight of their session was an archery demonstration by some of the residents with a team from the sporting goods firm Lillywhites.[5] An archery competition between Stoke Mandeville and a team from Windsor was also the topic of a report by the BBC in 1954.[6] Stoke Mandeville achieved further publicity in the sporting realm when Twentieth Century Fox filmed an archery competition for paraplegics and the resultant newsreel was shown in cinemas all over Britain.[7] Such films gave institutions such as Stoke Mandeville an important publicity outlet that might increase their income from charitable donations, while also demonstrating that there was an ongoing fascination with the war-wounded and their attempts to live a 'normal' life.

The sports that Guttmann had devised for the patients in the 1940s had grown in variety ten years later, although many of the activities that had been developed earlier were still practised. Archery continued to be a popular sport amongst the spinal paralysed during the 1950s but for different reasons to those of the medical profession who recommended it. As we have seen, for

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[4] Guttmann was the consultant neurosurgeon to the Star and Garter Home.
[5] As added drama, the patients were supposed to hit a microphone that was attached to the target, but unfortunately none of them were able to hit it. *Star and Garter Magazine*, Vol. 30, No. 4, (October 1950), p. 4-5.
[6] BBC News Archives, June 1, 1954.
[7] *The Cord*, Vol. 4, No. 1, (Winter 1950/51), p. 11.

medical practitioners in charge of the rehabilitation of paralysed patients, it developed compensatory muscles in the back, which helped with balance and strength, as Guttmann had realised in the 1940s. For the spinal injured, archery was a sport in which those in wheelchairs could compete against the able-bodied. As well as the improvement of the mental attitude of the paraplegic, testing their prowess against the able-bodied not only increased the number of competitors they could vie against, but also stimulated personal performance. Many of the Homes participated in shoots with able-bodied archery clubs in their local areas; for example, the Star and Garter Home competed in a monthly shoot against the London Archers Club throughout 1950.[8]

As well as the original activities of archery, netball and throwing the javelin, new games and sports were added throughout the 1950s to expand the Stoke Mandeville Games programme. There had been much discussion by the Games Committee throughout the early part of 1951 about the inclusion of recreational games for those that did not enjoy the more active forms of sport. This change may have been due to the fact that the population of the Spinal Unit was not wholly comprised of Service patients any longer, and there were numbers of civilians who resisted the sporting culture of Stoke Mandeville. With that in mind, in 1951 the organisers added snooker to the programme and included table tennis as a demonstration sport.[9]

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[8] *The Cord*, Vol. 3, No. 3, (Spring, 1950), p. 24-25.
[9] *The Cord*, Vol.4, No.4, (Autumn 1951), p. 13.

While many sports at Stoke Mandeville were variations on already existing games, there were some that combined features of more than one to develop a new game. Dartchery was a variation on archery that was devised by a group of paraplegics from Leeds.[10] Due to the often-inclement weather in Britain, many paraplegic archers were forced to practise on a short course in a gymnasium. In an attempt to compensate for the tedium of shooting at the same target from a short distance a paper cover depicting the scores on an archery board, greatly enlarged was placed over the usual target, and the points system was the same as for darts. Other sports were added throughout the 1950s in an ad hoc way, but generally they were able-bodied games adapted for people in wheelchairs. Possibly due to Guttmann's personal interest, fencing was demonstrated in 1954 and officially included in the Games in 1955. The archery rounds grew to include children up to twelve, and the fencing competition was expanded to include women in 1956. Shot putt joined javelin as a field event in 1957. In 1959, the pentathlon was introduced, a significant event in sport for paraplegics because of its gruelling nature which paraplegics had been considered too weak to manage. Inclusion of this event attested to the patient's general fitness levels as well as Guttmann's determination that the spinal paralysed would eventually be able to compete in similar sporting events to the able-bodied. Archery, swimming, and the field events of shot put, javelin and throwing the club were combined to make up the pentathlon.

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[10] *The Cord*, Vol. 5, No. 4, (December, 1952), p. 29.

New facilities at Stoke Mandeville made it possible to improve the varieties of therapy offered to patients as well as to include new activities for the sports day. An indoor pool was finished in 1953.[11] During the year, swimming provided the spinal injured and those paralysed from polio with another important type of exercise therapy, and it was also used for competitive purposes in the Games. At the 1953 event, three different classes were held in swimming, the backstroke, breaststroke and crawl.[12]

As well as facilities for sporting competition, infrastructure was also improved with new accommodation being built for international participants and their assistants. Prior to 1952 the lack of extra accommodation was not problematic as the competition only lasted one day, but when international participants began competing, attendance for the duration of the Games was impossible, and when the events spread over two days from 1955, funds had to be found for increased space as previously participants had overcrowded the wards on makeshift beds. Accommodation for visiting athletes was still found to be insufficient and was increased again in 1956. As the numbers of participants grew, so too did the number of spectators, so a stand was built to enable more comfortable watching.[13]

How were the extra funds for these improvements procured? While the Ministry of Pensions controlled the Stoke Mandeville Hospital until 1954, when

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[11] Construction of the pool was commenced in 1949.
[12] The favourite stroke of the patients, the 'Stoke Mandeville Paddle' did not feature in the swimming. It used a special arm movement, which compensated for the lack of buoyancy as a result of paralysis. *Bucks Herald*, (August 14 1953).
[13] *The Cord*, Vol. 8, No. 4, (October, 1956), p. 8.

it came under the auspices of the Ministry of Health, there was no money available for projects of this nature. This improvement and new construction was costly but the Games Committee was able to pay for them through the Paraplegic Sports Endowment Fund, which was established in 1955.[14] A large percentage of the money raised for these projects also came from the Royal Air Forces Association, maintaining Stoke Mandeville's link with the Services.

The Stoke Mandeville Games maintained a steady growth throughout the 1950s. In 1951, the pleas to hold them on a Saturday were recognised, which probably helped boost both the attendance figures as well as increasing the number of participants.[15] Many would-be athletes had previously missed the Games due to work commitments.

1952 was a benchmark year for the Games, as they included international competitors for the first time. Six members of an archery team from a military rehabilitation centre in Aardenberg, Holland arrived to compete in the archery events.[16] Their attendance was supported by sponsorship from the World Veterans Association, whose funding programme provided assistance with paraplegic sport for the war wounded.[17] Although the team from the Netherlands did not distinguish itself in terms of its standard of competition,

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[14] Guttmann and J.C.A. Faure of Unilever set up the fund in late 1955. *The Cord*, Vol. 8, No. 4, (October, 1956), p. 8. Money was raised through public donation and methods such as art exhibitions. *The Times*, (April 5, 1963).
[15] About 500 attended and there were 120 competitors, Scruton, *Stoke Mandeville*, (1998), p. 70.
[16] Guttmann, *Textbook of Sport for the Paralysed*, (1976), p. 24.
[17] World Veterans Federation, *Rehabilitation Bulletin*, Paris, (1960), p. 5.

they were presented with medals for being 'the first team from overseas to compete in the Stoke Mandeville Games'.[18] This was a meaningful moment in paraplegic sport, although little publicity given to it at the time. Even the local paper, the *Bucks Herald,* gave it scant space.[19] News of the Stoke Mandeville Games obviously reached other countries because in 1953 the group representing the Netherlands returned to compete again and was joined by teams from Canada, France, Finland and Israel.[20]

The arrival of the Dutchmen was not the only innovation of 1952. The complicated classification system, used in contemporary disabled sport had its roots in these games. Competitors were divided according to the location of the lesion or position where their spinal cord had been damaged, in order to ensure a fairer competition.[21] For instance, the class division in table tennis grouped the spinal lesions into classes 'a', 'b', or 'c', as some of the spinal lesions had to have their hand strapped to the bat, because they were unable to grip. Separate classes were also established for the javelin; one for lower and one for the higher class of lesion. The classification system continued to be refined. In 1956 the netball competition was split into two classes, for complete and incomplete lesions. Preliminary heats were held and the Games stretched over two days for the first time in 1955. The number of nations competing was still increasing with 18 teams including one from the

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[18] *The Cord*, Vol. 5, No. 3, (October 1952), p .21.
[19] The only time that any mention of Stoke Mandeville was on the front page of the *Bucks Herald* in the 1950s was in 1952 when a patient was arrested for bigamy. *Bucks Herald*, (July 25, 1952).
[20] *The Cord*, Vol. 6, No. 2, (Autumn 1953), p. 10.
[21] Naturally, this early system was more crude than the later refined divisions of the Paralympics. At the Stoke Mandeville Games, classifications were applied to paraplegics, as they were the only types of disabled involved.

United States, who easily won the basketball event due to their skill and lighter wheelchairs.

Winning the netball competition acquired a new status as less weighty and more manoeuvrable wheelchairs were manufactured and used by the British teams in an effort to defeat the seemingly unbeatable Pan Am Jets from America.[22] Efforts to beat the Americans proved impossible for the basketball teams at the Stoke Mandeville Games. The Star and Garter reported rather enviously on the Pan Am Jets lighter, polished aluminium chairs.[23] Although those in Britain were prepared to put their lack of success down to rationing, the real reason was probably that the Jets had some of the characteristics of a professional sporting team. They were sponsored by Pan American World Airlines, probably the first men's paraplegic sports team to be so supported.[24] With this assistance the company rented a gymnasium which allowed training three nights a week and Saturday and Sunday mornings. Even a professional coach, Junius Kellogg, a one time Harlem Globetrotter who had become paraplegic, was hired in 1958.[25] The British team did not have much chance of victory against such well-trained and funded opposition.[26] The removal of the Jets showed that those who organised the Games took them seriously; they were no longer an amateurish pastime of a few ex-servicemen and

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[22] The Pan Am Jets held the title for five successive years. Harriet May Savitz, *Wheelchair Champions: A History of Wheelchair Sports*, (New York, 1978), p. 25.
[23] *Star and Garter Magazine*, Vol. 35, No. 4, (October, 1955), p. 14.
[24] The Controller of Pan American Airlines established the Pan Am Jets when the head of the accounting department's daughter contracted polio. Savitz, *Wheelchair Champions*, (1978), p. 23.
[25] Ibid, p. 24.
[26] This professionalism eventually caused controversy, when in 1957 the basketball final between the Pan Am Jets and the Netherlands ended in the disqualification of the Americans for rough play. *The Cord*, Vol. 9, No. 4, (October 1957), p. 20.

women in wheelchairs, but an organised event with rules and regulations, infringement of which would not be tolerated.

Guttmann had made a post games speech in 1949 where he said that he hoped there would be a time when the disabled would have their own version of the Olympic Games. Throughout the 1950s, he copied some of the ceremonial events that were held at the Olympics, in an effort to emulate the celebratory structures of the Olympic movement. In 1951, for example, Stoke Mandeville's variation of the Olympic opening ceremony was organised for the first time. During this, about twenty female patients participated in Indian club swinging to music. The club swinging continued as part of the opening ceremony in 1953 and a special march was also composed for the Games that year.[27] The spread of internationalism prompted the addition, in 1954 of a 'wheelpast', which was a copy of the march past of Olympic nations, where the different grouped countries pushed themselves past a saluting base carrying their flag while the Stoke Mandeville march was played.[28] This wheelpast became a permanent feature of the Games after that year. Famous sporting personalities and Olympic competitors were invited to the Games to further increase their legitimacy. Roger Bannister awarded prizes at the 1955 Games and said in his speech,

> ...It had been borne home to him very forcibly that sports men and sports women with the same the world over: the American netball

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[27] *Bucks Herald*, (August 14 1953).
[28] *The Cord*, Vol. 7, No. 2, (September 1954), p. 7.

> players, for example, this afternoon had exhibited the same enthusiasm as he had found amongst the American Olympic teams, and he had noticed the same excitement and the same tense atmosphere in all the events which he had been privileged to watch.[29]

The emulation of the Olympics was rewarded in 1957 when the International Olympic Committee presented the Fearnley Cup to the 1956 Stoke Mandeville Games. The Cup was presented to any sports club or organisation for 'meritorious' achievement in the Olympic movement.[30] Arthur Porritt, a leading member of the BOC, announced that 'nothing could exemplify more the spirit of the Olympic movement than the Stoke Mandeville Games'.[31]

In giving the prize, history was made as this was the first time that the Cup had been presented to a sporting group of disabled people, and apparently the first time it had been presented to any one in Britain.[32] For those involved in them, the Stoke Mandeville Games acquired a whole new legitimacy. The award of the Fearnley Cup only increased Guttmann's enthusiasm for copying Olympic ceremonies. Instead of a torch relay, a scroll was presented in Manchester to one of four 'runners' who relayed it to Stoke Mandeville, by car and wheelchair and the integrity of that first opening ceremony was in no way

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[29] Roger Bannister was also a neurologist, so he may have had professional interests in the work of the Spinal Unit at Stoke Mandeville. *The Cord*, Vol. 7, No. 5, (October 1955), p. 14.
[30] 'Sir Thomas Fearnley, Honorary member of the IOC, founded the Cup in 1950. *The Cord*, Vol. 9, No. 2, (March 1957), p. 8.
[31] *The Cord*, Vol. 9, No. 2, (March 1957), p. 9.
[32] *The Cord*, Vol. 9, No. 4, (October 1957), p. 13.

diminished by the fact that the final runners' unreliable motor chair had broken down several miles outside the village.[33]

In 1958, the shape of the Games changed once again. In Britain, it was decided to hold National Games in the spring to select a team to compete in the International Games in the summer. There were several reasons for this, which included both prestige and more practical considerations. This was important as it meant that the event was no longer an occasion where any and all disabled people came to play games, but instead was a serious competition in which only the best could participate. With the increase in the number of teams from overseas wishing to attend, it was becoming more difficult to accommodate them. A National Games would provide one British team and would remove the over representation of Britain as generally each hospital and Home had fielded its own team in the past.

The International Stoke Mandeville Games for the Paralysed really came of age in 1960 when 400 competitors from 21 countries went to Rome and took part in their own Games from the 18th to the 25th of September.[34] Guttmann wrote that it was

> ...the real fulfilment of the dream. For the first time, these Games followed closely upon the Olympic Games in Rome; competition was under Olympic rules and took place in one of the Olympic stadiums.[35]

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[33] *The Cord*, Vol. 10, No. 4, (October 1958), p. 16.
[34] Guttmann, *Spinal Cord Injuries*, (1973), p. 395-6.
[35] Guttmann, 'The Stoke Mandeville Games', *Australian Journal of Sports Medicine*, Vol. 2, No. 9, (March 1969), p. 22.

That statement stretched the truth somewhat, as the Italian authorities had denied access to the Olympic stadium at the last minute save for the opening ceremonies. Sporting events actually took place in a stadium 40 minutes bus ride away from the Olympic Village. Although the participants were allowed to stay at the Village, they were refused permission to stay in any accommodation that was serviced by a lift, so ramps had to be built to get them to their apartments, which were themselves built on stilts. Apart from the Village, the only other venue that they were allowed to use was the Olympic swimming pool.

Although there were no new sports at the 1960 Games, established competitions were further expanded. A F.I.T.A[36] round was introduced into the archery as was precision javelin throwing. It was difficult to complete the entire programme because the Italian authorities had made mistakes, for example, by putting the snooker table, specially imported from Britain, in the middle of the running track.[37] On the whole, however, the Games were seen as a great success and provided more publicity and legitimacy for the idea of sport for disabled people.[38]

It must be borne in mind that the teams of sports men and women who participated in the Stoke Mandeville Games throughout the 1950s were still

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[36] F.I.T.A. Round was used by the able-bodied and consisted of 36 arrows shot at four different distances. *Report of the 1960 International Stoke Mandeville Games for the Paralysed in Rome*, (1960), p.19.
[37] *Report on the 1960 International Stoke Mandeville Games for the Paralysed in Rome*, (1960), p. 80.
[38] There was only one report in the newspapers which was a photograph of the United States and Israel playing a game of wheelchair basketball. *The Times*, (September 22, 1960).

mainly from the Forces. As we can see from *The Cord*, until 1958 the British teams mainly represented ex-servicemen's homes, as did many of the overseas teams. The civilians who formed the bulk of new patients at the Unit were not as heavily involved in the Games in the early years, yet remedial exercise and sport remained important facets of their treatment. The sporting emphasis however, was not enjoyed by all of the patients. Jim Porteous, paralysed by polio wrote:

> I found Stoke Mandeville tough, I would liken it to a concentration camp in terms of its regime. You had a tight programme and you can bet your sweet bippy that the bloody table tennis is at the other end of the hospital from the club swinging.[39]

As well as their sometime unwilling participation in sport, Guttmann also continued to experiment on his patients within the field of medicine. In 1954, Stoke Mandeville opened its own research unit, where clinical staff and those from other countries studied the patients. There was research carried out into aids for the paralysed, as well as Guttmann's on-going work on thermoregulation.[40] There was also research into the fertility of paraplegic women. 1954 was an important year as the first baby to be born to a paralysed woman was delivered at Stoke Mandeville that year.[41] As well as these more traditional medical findings, one of Guttmann's favourite investigations was to test the sporting prowess of those patients with spinal

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[39] Jim Porteous in Gould, *A Summer Plague(*1995), p. 240.
[40] This basically means the body's ability to regulate and adapt its internal temperature. Guttmann, *Spinal Cord Injuries*, (1973), p. 640.
[41] In fact there were three that year. *The Cord*, Vol. 7, No. 3, (December 1954), p. 8.

injuries against the able-bodied. One of these experiments was carried out in 1956, when Guttmann had the paraplegics at his hospital throw javelins against the British Olympic team. When the able-bodied thrower was sat in the wheelchair, he threw only four inches further than the disabled thrower.[42] Experiments of this type proved to Guttmann to what extent rehabilitation through exercise and sport had helped disabled people regain their levels of fitness.

Although for much of the public, the heroic sporting efforts of the war disabled such as those from Stoke Mandeville or individuals like Douglas Bader were much acclaimed, there were other groups of disabled who did not have access to the facilities of the war wounded. As we have already shown, there was a gap between what was available to the war wounded and what was on offer to the civilian and industrial disabled. Some miners' clubs, for example, organised archery practise for both their able-bodied and disabled members[43], and they were fortunate that they were included in the Stoke Mandeville Games. This inequality extended to recreational and sporting equipment. Guttmann recognised the value that sport had given to many paraplegics and wanted to extend this to others around the country. At the end of 1950, a Sports Fund was established at Stoke Mandeville to promote sport outside ex-service hospitals and provide sporting equipment, especially for those disabled living at home who were unable to have the advantages of these

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[42] Goodman, *Spirit of Stoke Mandeville*, (1986), p. 155.
[43] PRO BX4/30 National Survey of Paraplegic and Seriously Disabled Miners, 1955.

facilities.[44]

The Services continued to use sport and games as part of their own rehabilitation programmes. Throughout the 1950s, conflicts such as the Korean War[45] and the Suez Crisis[46] provided a small number of wounded servicemen, some of who suffered permanent residual disability. This meant that the Services still had a rehabilitative role to play. It was felt in some quarters that the war wounded would benefit from physical exercise and sport more because it was perceived as a way of recapturing their youth before injury, which would assist their recovery both psychologically as well as physically.[47] Preferential rehabilitation treatment for the disabled ex-servicemen still existed.

It appears that the normal provision for the rehabilitation, training and resettlement of disabled persons, coupled with the generous help given by the voluntary societies or organisations, and the War Pensioners Welfare Service, ensures that the particular needs of the ex-service are kept well to the fore.[48]

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[44] *The Cord*, Vol. 4, No. 1, (Winter 1950/51), p. 14.
[45] 2,498 men were wounded in Korea. David Childs, *Britain Since 1939*, (London, 1995), p. 99.
[46] Richard Lamb, *The Failure of the Eden Government*, (London, 1987), p. 268.
[47] Josephine L. Rathbone and Carol Lucas, *Recreation in Total Rehabilitation*, (Springfield, 1959), p. 317.
[48] *Report of the Committee of Inquiry on the Rehabilitation Training and Resettlement of Disabled Persons*, 1956.

In 1955, the Army Medical Rehabilitation Unit was set up in Chester.[49] One of the changes from the immediate post-war period was that those who were injured spent 90% of their time with a physical training instructor.[50] The practise of keeping on men whose disablement would be permanent was also continued; they were rehabilitated as far as possible and only then invalided out of the Forces.[51] The success rate was high, often only minor residual disability occurred which meant a rate of approximately 85% returning to their units.[52] The instructors devised special games such as sitting basketball for amputees and those with broken limbs. Of course it was not war wounds that were the main cause of disablement; at the Saighton Camp in Chester; patients were there more often due to sporting and automotive accidents.[53]

The Royal Air Force, so successful at rehabilitating the seriously wounded during the war, continued to provide similar services for those in peacetime. As with so many of these rehabilitation centres, many adapted sports in lieu of repetitive exercises were devised. These sports often had no longevity and nor achieved national status, but were an important part of the rehabilitative process. At the RAF centre at Chessington, for example, the game of 'slide football' was played, where the players would move in a crab-like manner, in a sitting position and then move about on hands and feet, and try to propel the ball through their opponents goal.[54]

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[49] The camp was closed in 1968. CMA RAMC O/S 39.778 Photograph Book from Saighton Camp, 1956-1968.
[50] CMA RAMC O/S 39.778 'Army Medical Rehabilitation Unit', 1956-1968.
[51] Ibid.
[52] *Liverpool Daily Post*, (June 22, 1960).
[53] *Soldier*, (September 1959), p. 12.
[54] 'Venture with the Royal Air Force', *St Mary's School of Physiotherapy (Swedish Institute) Magazine*, (1957-1958), p. 8.

The rehabilitative lessons and techniques adopted during the war were extended and modified in post-war Britain, and the medical establishment made remedial exercise an important part of recommended treatment.[55] Rehabilitation continued to be crucial for recovery after major injury, and the knowledge was passed on, not only to Services patients, but also to people who had been disabled in industry. Physical exercises and training began to form an important part of the process of restoration for many disabled people. Immediately following the war there was some anxiety that staffing levels for these rehabilitation centres and hospitals was insufficient, and that employees should be correctly trained.[56] Many of the workers were formerly physical training instructors in the Army, who had retrained at Pinderfields EMS Hospital in Wakefield,[57] which ensured that the military model of rehabilitation continued to be a part of the rehabilitation regime. Although there was some demarcation of rehabilitation for example, the medical, which took place in hospital, and the industrial, which took place in an industrial training establishment, physical exercise formed part of both. Industrial training was often a combination of remedial exercise in hospital and instead of the typical occupational therapy, a period in a factory for industrial training.[58] At Garston Manor, a medical rehabilitation centre opened in 1951, golf, bowls and table tennis provided recreational forms of rehabilitation for the broken bones, amputees, bronchial, arthritic and head injury patients.[59] Establishments to treat the disabled in industry were still expanding their use of exercise and

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[55] *British Medical Journal*, (December 1, 1951), p. 1331.
[56] PEA 1/7 Minutes of Executive Committee Meeting , Letter from H. Balme, Ministry of Health to the Executive Committee,15 June 1945.
[57] PEA 1/7 Minutes of Executive Committee Meeting, 21 September 1945.
[58] *British Medical Journal*, (April 28, 1951), p. 931.
[59] *Pamphlet for Garston Manor*, (undated, presumably 1968).

rehabilitative practices, and developed specific exercises for certain conditions. Miners from South Wales with pneumoconiosis, for instance, had their own particular type of rehabilitative activity. Since inhaling coal dust caused the disease, adapted games were used so the miners could improve their lung capacity.[60] One particular exercise involved a variation on table tennis, where instead of playing table tennis with a bat, the patients would blow the ball across the table at one another.[61] The disabled dockworkers who attended the special establishment set up for them at Claremont were also provided with remedial gymnastics.[62] Egham in Surrey was originally opened as a retraining centre for those injured in war, but later expanded to include those hurt in industry. By 1952 there were fourteen of these industrial training centres operating, and many of them used remedial exercises and games to assist with the rehabilitation process.[63]

Physical activity was important, not only for those who were commencing rehabilitation treatment, but also for the on-going general health of disabled people. In Ministry of Health Circular 32/51 the powers of the local authority was set out when dealing with the disabled. One of these was to encourage participation in clubs and assist with transport to places of recreation where facilities would be provided for games.[64] The Minister of Health, Hilary Marquand said,

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[60] Davies, 'Rehabilitation and Resettlement in Pneumoconiosis', *Rehabilitation*, No. 1, (January 1951), p. 12.
[61] Alan L. Bass, 'Functional Approach to Chronic Bronchitis', Rehabilitation, No. 40, (January-March 1962), p. 26.
[62] 'Notes and News', *Rehabilitation*, No. 5, (July 1952), p. 28.
[63] This included two in Scotland and one in Wales. PRO MH 55/2158, Interim Report from the Industrial Rehabilitation Development Committee to The Secretary, Ministry of Labour and National Service, December 1952.
[64] *Rehabilitation*, No. 3, (December, 1951), p. 26.

It is a measure of reasonable economy so that these handicapped people can take their place in the full life of the community. I am sure that it will not be a wasteful or expensive scheme, but one which will yield an economic return to the community.[65]

Rehabilitative methods were also extended to provide a means of exercise for those with sensory disabilities. In the 1950s, for example, the Margaret Morris movement was used to provide remedial exercises for blind people, which would ensure that they had good balance and more awareness of their bodies. Courses for the blind were established in regional centres, as was one in London, in which balance and movement to music was taught.[66]

Another activity that had some rehabilitative aspects for blind people was judo, which was first taken up in 1951. Judo helped with confidence and balance, as well as providing another activity in which the blind could participate. The first blind person in Britain to take up the sport was apparently inspired by an article about two members of the British International Judo team who had taken part in a bout when blindfolded.[67] Maurice Lovell attended a club for the able-bodied and achieved his instructor's grade so that he could teach judo to other blind people.

While remedial exercises and some sports were being attempted by blind

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[65] *Rehabilitation*, No. 3, (December 1951), p. 26.
[66] *The New Beacon*, Vol. 36, No. 424, (April 1952), p. 84.
[67] *The New Beacon*, Vol. 35, No 418, (October 1951), p. 236.

people probably for the first time, other groups of blind people continued to play sport and games at a competitive and recreative level. Participation in walking races continued to be popular with blind war wounded from St Dunstan's, and in the 1952-53 season, nine races were held from September to May, with distances of between 2 to 15 miles.[68] Generally these walking competitions were also for the able-bodied, for example, the AA sponsored the Stock Exchange London to Brighton race and men from St Dunstan's were accepted as competitors which suggested that issues surrounding the use of escorts had been solved. The blind continued to improve their times in these competitions. In 1955, a blind man from the Home, Billy Miller, came in third overall in the race and received the St Dunstan's Cup which was presented to the first St Dunstaner to finish.[69] Apart from the sports day and the indoor sports, the walking races dominated the sporting calendar of St Dunstan's. Of course ex-servicemen did not always want to participate in sport. In the same way that there was a call for the blind from St Dunstan's to give sport a try after 1918, the exhortations for blind sport also was a rallying cry after 1945. The St Dunstan's Review, trying to get more ex-servicemen to join in their walking races, queried:

> ...are you content to sit around and let the only sport you take part in be the Saturday afternoon broadcast from some professional stadium?[70]

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[68] The participation of the blind in the Stock Exchange races continued throughout the 1950s. *St Dunstan's Review*, Vol. 36, No. 398, (October 1952), p. 3.
[69] *St Dunstan's Review*, Vol. 38, No. 427, (June 1955), p. 3.
[70] *St Dunstan's Review*, Vol. 34, No. 382, (April 1951), p. 5.

While walking still retained some popularity, other events did not fare so well. The St Dunstan's Sporting Gala continued to be held at Ovingdean where it had been inaugurated in 1918. Competitions included running races, throwing events and other fun events such as wheelbarrow races, sack and three-legged races. The Sports Day was competitive, participants were divided according to ability, with veterans separated from athletes and there were sections for both women and children. But these events were secondary to the walking races in importance. Although the Sports Day continued to be held, it declined in popularity during the late 1950s. In 1959 for instance, the St Dunstan's Review remarked in its report that,

> It has been a disappointment that over the last year or so there has been a noticeable decline in the number of St Dunstaners taking part in the field events. Whilst realising that this is largely due to the fall in the number in training in Ovingdean, we nevertheless have noticed that there is less readiness on the part of the younger men on holiday to enter for the events and, therefore, we especially congratulate those older men of World War I who are still very much in the running![71]

There were several explanations for the lack of interest. By the 1950s there were a wide range of other activities open to blind people. As they were accepted by the wider community, theirs was a well recognised and organised disability, there may have not have needed a sense of belonging or the need to prove their 'normality' that participation in sport provided for the paralysed.

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[71] *St Dunstan's Review*, Vol. 43, No. 472, (July 1959), p. 8.

Although there had been a sense of camaraderie forged through St Dunstan's, especially for the First World War veterans, it was a crutch that many did not need as they found their place in the wider world. It was evident that the newly blinded from the Second World War, possibly because they included civilians[72] as well as servicemen and their numbers were not as great, did not share the early St Dunstaners enthusiasm for games and sporting activities.

Despite the seeming decline in enthusiasm for sport at St Dunstan's, games were also organised by the RNIB's various branches and were held throughout the year. These events included swimming galas, which were held once a year by the different regional blind clubs. The blind also continued to play football. Although the goal kicking, described in chapter two and so enjoyed by those at St Dunstan's in the 1920s had disappeared it had been replaced by indoor football for the totally blind. The boundaries provided by the walls of the gymnasium ensured that they could play their version of the national game in relative safety. Some forms of blind football continued to be played, and partially blind would play other teams, including the able-bodied, whose only departure from the normal game was that the ball was white.[73]

Participation levels in recreational activities also increased. Tandem cycling, for example, became popular in the latter half of the 1950s. Sighted people

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[72] Only members of the Services blinded in war were allowed to join St Dunstan's, PRO MH 5S/1088, General Correspondence with St Dunstan's, 1941-50..
[73] *The New Beacon*, Vol. 39, No. 457, (January 1955), p. 18.

gave lessons in Richmond Park, and when the blind rider attained a level of proficiency, they would take them out on the road.[74] Other sports that relied on the assistance of a sighted person included skiing, in which blind people increasingly took part during the 1950s.[75]

While blind people enjoyed a wide range of their own sporting activities, which were reported in their own journals, there was little in depth coverage of able bodied sporting activity that the blind could read in Braille. This was changed on 5th August 1953 when the *Braille Sporting Record*, a version of the *Sporting Record* commenced publication on a weekly basis.[76] Earlier, both the cricket and football fixtures were listed in Braille for the first time.[77] It was decided to include many more suggestions for Braille diagrams when the *Braille Radio Times*, normally an entertainment and listings magazine, carried a copy of the Derby course at Epsom.[78] Although reporting on able-bodied sporting events were appearing in printed form for blind people in the early 1950s, they still relied heavily on the radio for their information and received their radio license free.[79] When only half of the Cup Final was broadcast in 1953, for example, blind people wrote letters to Members of Parliament and Club Chairmen of various teams, trying to explain the distress that it caused them.[80] Once again the preference for blind people was evident, as deaf

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[74] *The New Beacon*, Vol. 40, No. 473, (July 1956), p. 106.
[75] There were only a few blind British people that attempted this sport, as it was very expansive to learn. *The New Beacon*, (June 1959), p. 4.
[76] *The New Beacon*, Vol. 37, No. 441, (September 1953), p. 205.
[77] *The New Beacon*, Vol. 34, No. 407, (November 1950), p. 228.
[78] *The New Beacon*, Vol. 44, No. 519, (July 1960), p. 184.
[79] There were some calls in the 1950s for the blind to receive television licences for free too, but it was argued that, as television was essentially a visual medium that this would be inappropriate.
[80] Letters, *The New Beacon*, Vol. 37, No. 437, (May 1953), p. 117. and Vol. 37, No. 439, (July 1953), p. 163.

people received no concessions or the cost of their television licenses. Although many relied on the radio to provide them with reports on sporting action, blind people still attended football matches, and those who suffered their blindness as a result of war could still gain free entry. One deaf blind man attended the Cup Final at Wembley with his wife in 1953 and she signed the action of the play on his hand using the special language used for those without sight or hearing.[81] While blind people enjoyed both listening to and in some cases, participating in games, there was still no official or international competition for blind people, similar to the Stoke Mandeville Games.

For amputees in the 1950s the situation was very different from that of the spinal paralysed and perhaps more similar to the blind. Medically, their state of health was much less precarious that that of the paraplegic. They did not have to control recurring infections that might require hospitalisation. Amputees were better able to integrate themselves within wider society insofar as their disability did not always affect their playing of able-bodied sport though with a few adaptations. However, in 1959 at a conference in Helsinki, the British representatives of BLESMA learned that rehabilitation did not only involve getting an amputee back to work, but also keeping his level of fitness up to a certain level.[82] Upon their arrival back in Britain, the delegates set about spreading the word of fitness to amputees everywhere. This move toward a concern for greater fitness for amputees culminated in their own sports days, which were usually held at Stoke Mandeville during the 1960s.

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[81] *The New Beacon*, Vol. 37, No. 442, (October 1953), p. 241.
[82] Ryde, *Out on a Limb*, (1982), p. 84.

While generally amputees were able to participate in able-bodied sport, there were some competitions open to amputees only, including the Silver Tassie Tournament at Gleneagles in July 1957.[83]

The polio pandemic of the 1940s and 1950s increased the numbers of those with residual disability. As we saw in Chapter Four, medical practitioners had previously judged exertion to be harmful for those with early onset of the disease. After the pre-paralytic stage was over and the condition had settled, remedial therapy was introduced. One of the most important, in fact 'the only method required' was active exercise both in slings and in a swimming pool, which helped build muscles in a weightless environment.[84] There was a certain irony to this as many swimming pools had been closed as they were seen as places of contamination, felicitating the spread of the virus.[85] For some patients with residual disability, the therapy eventually progressed to a competitive level, and the first sporting event for those with polio was a Swimming Gala in 1955.[86]

Polio was also the catalyst for the recognition in the 1950s of the therapy of riding for the disabled. Although the treatment has a long history, and had been systematically studied as early as 1875,[87] it was the 1952 able-bodied Olympics where it achieved international awareness. A woman who had been

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[83] The title comes from the Sean O'Casey play of 1928. *The Times*, (July 12, 1957).
[84] *British Medical Journal*, (June 30, 1951), p. 1511.
[85] Chlorinated pools were seen as source of infection as they irritated the nasal passages. See *British Medical Journal*, (September 9, 1950), p. 625, (September 23, 1950), p. 728, & (October 21, 1950), p. 950.
[86] Barry North, *Something to Lean On*, (Middlesex, 1999.), p. 73.
[87] For and early history see Adrian M. Bain 'Pony Riding for the Disabled' in *Physical Therapy*, Vol. 51 (1965), pp. 263-265, & Robert P. Mayberry, 'The Mystique of the Horse is Strong

included on the Danish Dressage team had suffered polio in 1944. Lis Hartel had recommenced riding horses after she had recovered from her early paralysis. Riding had become a form of rehabilitation for her and she believed that the muscles that had been wasted by her disease had been massaged and strengthened by it. Hartel had to be lifted onto her horse, but once she was astride it won a silver medal in the dressage competition. Not only was Hartel disabled, she was female, and had displayed a courage that was usually only attributed to men who had been injured in the war, which led Hartel to later claim that her success had been treated in a somewhat 'sensational' manner. Obviously pleased with her Olympic achievement, she wrote,

> I am still more grateful for the wider versions of its significance which manifested itself in the thousands of letters from fellow-sufferers all over the world who had either gained new courage or sought advice from one who had been destined to bear the lot that was mine.[88]

Hartel's influence reached farther than the shores of her native Denmark. A centre for riding ponies for the disabled was established in Norway shortly after Hartel's achievement.[89] Within two years, centres had been established in England for disabled children to ride ponies.[90] Riding for the disabled as a type of treatment appeared to have more of an impact on the medical

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Medicine: Riding as Therapeutic Recreation', *Rehabilitation Literature*, Vol. 39, (1978), pp. 192-196.

[88] Lis Hartel, 'As Young as Your Courage', Ian Fraser, (ed.), *Conquest of Disability*, (London, 1956), p. 18.

[89] Bain, 'Pony Riding for the Disabled', *Physical Therapy*, Vol. 51, (1965), p. 263.

[90] Riding for the Disabled Association, *The Spirit of RDA*, (Warwickshire, 1995), p. 29.

practitioners in mainland Europe, but in Britain the therapy was taken up by physiotherapists and private individuals. A physiotherapist from Winford Orthopaedic Hospital near Bristol and a Mrs Jacques who lived in Chigwell organised the first forays into riding ponies as a type of treatment for a range of disabilities, including cerebral palsy and paraplegia.[91]

At Tixover Grange, which was the school for those with cerebral palsy opened by the entertainer Wilfred Pickles, riding for the disabled was part of the curriculum. Pickles gave a pony and a donkey to the school, in order that the children could participate in a fun activity that would augment the gruelling hours of physiotherapy.[92] Like those with polio, It was believed that riding was good therapy for those with cerebral palsy, which was still in the early stages of knowledge of suitable treatment. While not offered as a type of rehabilitative therapy, blind people also continued to enjoy riding horses. The workers from the Ford Motor Company at Dagenham gave a pony to the Chorleywood Grammer School for blind girls in 1959.[93] From its relatively small beginning, riding for the disabled expanded to encompass a wide range of disabilities that included those with learning difficulty.

At schools for disabled children, sport and games continued to be played and formed an important part of their rehabilitation and fitness regime. While this therapy was considered important, provision varied between different disabled groups and the individual schools. Some schools tried to provide the best

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[91] B.S. Regester, 'Riding as a Treatment for the After Effects of Poliomyelitis', *Rehabilitation*, No. 28, (January-March 1959), p. 31.
[92] Richard Dimbleby, *Every Eight Hours*, (London, 1964), p. 61.
[93] *Royal National Institute for the Blind Annual Report* 1959.

facilities. Swimming was considered one of the best forms of therapy and pools were built at many schools.[94] Often there was no government funding provided for this very important but expensive sporting facility, for example, the pool built at the Royal School for the Blind, opened in August 1950 was built through donations and subscriptions.[95]

Considering the importance that was placed on recreation for many disabled children, there seemed to be a marked lack of interest in it during some inspections by the Ministry of Education in the early part of the 1950s. For instance, at Exeter St Loyes, which was a school for children with a range of disabilities including cerebral palsy, only one report for the period mentions recreation, which said, 'Plenty of ground around for games. Football attempted by the boys. Said to be much enjoyed by the C.P.'s'.[96] As well as offering able-bodied sports, schools also modified games in order that disabled children could participate. An example of this was a game played at Worcester College where a football was used as the ball to play a form of cricket.[97]

Charities continued to use sport by the able-bodied as a way to financially benefit disabled people. Some of these included celebrities as well as

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[94] Other children were taken to their local swimming baths every week. 'Swimming at the Vale Road School for Physically Handicapped', *Special Schools Journal*, Vol., 45, No. 2, (June 1955), p. 27.
[95] *The New Beacon*, Vol. 34, No. 404, (August 1950), p. 172.
[96] C.P.'s refers to those with cerebral palsy. PRO ED 62/178, Report on Exeter St Loyes visited 5 February 1953. The reports for 1954 and 1955 in the same file do not contain any further reference to recreation or sport.
[97] For example, the batsman was given two chances at lbw, the ball had to bounce twice as it was being bowled and a batsman was out if a fielder caught the ball after it had bounced once. *The New Beacon*, Vol. 38, No. 454, (October 1954), p. 238.

sporting personalities who would support a charity which provided for disabled people, as well as public exposure for themselves. The State Organisation for Spastics, for example, organised a cricket match between test cricketers and a Variety XI captained by Tony Hancock which was held at the Lyons Sports Ground at Sudbury where in the first year 5000 people attended or bought programmes.[98] Other fund raising was less organised. BLESMA used sporting events such as cricket matches, football games and darts competitions to raise funds with a casual 'passing round of the hat'.[99] Sir Victor Sassoon, whose horse Crepello won the Derby in 1957, sent £100 of the prize money to St Dunstan's.[100] Other less prestigious mounts earned money for the disabled. The Wivelsfield Donkey Show and Race Meeting benefited both the Heritage Craft School at Chailey and the Sunshine Fund for Blind Babies.[101] Ex-servicemen's homes continued to receive visits from famous sporting celebrities and journalists performing their charitable duty. A notable event at the Star and Garter Home included a visit from various sporting journalists who answered questions from the patients and staff with Arthur Cook of the Daily Express acting as Chairman.[102] This proved so popular that it was repeated in January 1958 this time including players and television celebrities.[103] As well as being entertained at home, ex-

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[98] This event existed for about two years and then was dropped as it was considered that good weather could not be guaranteed and the games were dropped. Dimbleby, *Every Eight Hours*, (1964), p. 40.
[99] Ryde, *Out on A Limb*, (1982), p. 76.
[100] Interestingly the deaf jockey Lester Piggott rode the horse. *St Dunstan's Review*, Vol. 41, No. 450, (July 1957), p. 7.
[101] *The New Beacon*, Vol. 39, No. 462, (June 1955), p. 137.
[102] The reporters included Desmond Hackett from the Daily Express, Peter Wilson from the Daily Mirror, Clifford Webb from the Daily Herald, and Roy Peskett from the Daily Mail. *Star and Garter Magazine*, Vol. 34, No. 2, (April 1954), p. 7.
[103] Television celebrity Eammon Andrews, journalists, Peter Wilson, Peter Laker and Bob Butchers, Clifford Webb and Victor Barna, the international table tennis player attended the discussion. *Star and Garter Magazine*, Vol. 38, No. 3, July 1958.p.9.

servicemen, for example from the Star and Garter, still went to Chelsea and Fulham football matches for free. This was a regular occurrence for ex-servicemen, but remained less common for the civilian disabled. In 1951 a group of boys were taken to see the cricket match between South Africa and Hampshire.[104]

While the majority of those participating in sports and games for the disabled were men due to their earlier role in the dangerous business of industry and war, there were still some opportunities provided for exercise for disabled women. Sexual stereotyping of women did not limit itself to the able bodied.

> Games are much less important to girls and though she has troubles enough ahead of her the handicapped girl may be fairly content with making progress in her schoolwork and becoming good at knitting or sewing.[105]

Stoke Mandeville had important ramifications for exercise for women with spinal injuries and it was as a direct result of the Games that women began to compete internationally in wheelchairs sports in Britain much earlier than women in other nations. American women did not participate until 1962,[106] while women in Britain had been competing in the Stoke Mandeville Games since 1948. They had fielded their own teams at the Games, and had played combined women's and men's netball at Stoke Mandeville in the late 1940s,

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[104] *The New Beacon*, Vol. 35, No. 417, (September 1951), p. 200.
[105] Kershaw, *Handicapped Children*, (1961), p. 40.
[106] Savitz, *Wheelchair Champions*, (1978), p. 47.

and continued to compete throughout the 1950s. Guttmann had even developed specific types of activity that he felt would appeal to his female patients, which included club swinging, demonstrated at the 1954 Games.[107] However, there were fewer events for women to enter at Stoke Mandeville, and until 1959 they had been excluded from the field events. Blind women also competed in the sports days organised by the NIB, and as we will see in chapter eight, deaf women played games and took part in outdoor activities.

Able-bodied women continued to provide what were believed to be fair combatants for disabled men, as we saw previously in Chapter Two. Women visiting the homes where disabled ex-servicemen lived no longer arrived to minister to the men; they came armed with sporting equipment, and provided strong competition. The team from the Star and Garter Home, for example, was dismayed when they were well beaten at table tennis by a group of female telephone exchange operators in March 1951.[108]

Although activities for disabled people were growing throughout the 1950s, neither they nor Stoke Mandeville was considered important enough to feature in its own right when the Wolfenden Committee commenced its investigation of UK Sport in the late 1950s. It had been appointed to explore the problems within British sport and also to make recommendations in order that sport could play its full role in the welfare of the community.[109] The questionnaire that was distributed in 1958 was sent to all national bodies that

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[107] Guttmann had been so impressed with the chorus girls swinging clubs in Paris, he decided to see how it could be utilised to improve the fitness of paraplegic women. *The Cord*, Vol. 4, No. 4, (Autumn 1951), p. 9.
[108] *The Star and Garter Magazine*, Vol. 31, No. 2, (April 1951), p. 17.

were represented by the Central Council for Physical Recreation.[110] Guttmann wrote to Wolfenden in April 1958 asking if the Committee would include the subject of sport for the disabled.[111] Although Guttmann was listed in the back of the report as having given written evidence to the Committee, there was no mention of disabled sport in the 1960 report.[112] When he was later criticised for this, Wolfenden's response was that he did not think of disabled people and their activities as a separate entity, and was quoted in the journal *Rehabilitation* as saying,

> Those men and women and boys and girls who were handicapped in this kind of way were a part of the whole community with which we were concerned and not persons who were set apart from it.[113]

Sport and exercise for disabled people was seen in a positive light, as it was understood to provide not only a standard of fitness which would assist a disabled person coping better with their disability, but also for its psychological benefits. While this was generally accepted, not all specialists believed that sport was beneficial to the disabled. Certain doctors argued that sport was unhealthy and placed undue strain on the disabled body. Some believed that paralysis was far too serious a disability and that heavy exertion was particularly dangerous for these people.[114] As well as the objections on

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[109] *The Lancet*, (October 8, 1960), p. 799.
[110] PRO ED 169/73 WCS/74, The Wolfenden Committee on Sport Questionnaire.
[111] CCPR Archives, Letter from Ludwig Guttmann to John Wolfenden, 16th April 1958.
[112] *Wolfenden Report*, 1960.
[113] 'Sport and the Community', *Rehabilitation*, No. 68, (January-March, 1969), p. 26.
[114] M. Hackenbroch, 'Physiological and Clinical Aspects of Sport for the Disabled', International Council for the Care of Cripples Conference, (London, 1958), p. 306.

medical grounds, there was another argument why disabled people should not play sport. There was still the voyeuristic reason for watching disabled sport, which had been prevalent in pre-twentieth century freak shows.

> Even with the increase in the number of such competitions in various countries they still have a curiosity value which is quite undesirable and which is very difficult to eradicate.[115]

But despite the sceptics, sport and exercise were generally seen in a positive light by both doctors and disabled people alike. Apparently, disabled sport was also good for able-bodied people too. It was argued by specialists like Guttmann that watching the disabled play sport helped those able-bodied to appreciate the disabled abilities rather than their disabilities.[116] Guttmann cited the example of the one thousand spectators who attended a wheelchair basketball game in France in 1956.

> ...their faces showed embarrassment and fear when they saw the paraplegics chasing round and crashing into each other in their chairs...As the Chairman had pointed out, it was a kind of rehabilitation of the able-bodied toward the disabled.[117]

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[115] J.G.P. Williams, *Medical Aspects of Sport and Physical Fitness*, (Oxford, 1965), p. 185.
[116] Curtis Campaigne, Secretary General of the World Veterans Federation, in discussion at the International Conference for the Care of Cripples Conference, 1958, p. 314.
[117] Guttmann, 'The Significance of Sport in the Rehabilitation of the Disabled', International Society for the Welfare of Cripples, *Planning for Victory Over Disablement*, (London, 1958), p. 297.

There was certainly expansion and contraction in disabled sport. The blind were attempting more diverse sports which split the cohesion that St Dunstan's had provided after the First World War. Stoke Mandeville remained the most connected group, their sport was tied directly to the fact that they were under Guttmann's authority. Sport still figured prominently in the rehabilitation process, especially amongst those that had suffered disability as a result of war, although units for those injured in industry were growing and using physical exercise and sport to refit those injured for work. The hardest working group of sporting war wounded were those from Stoke Mandeville. They had been the pioneers of organised disabled sport. That is not to say that other disabled groups were not participating in it, but that Stoke Mandeville was in the process of setting up rules and classifications for disabled people long before any other association had done so. This was possibly because the spinal paralysed had to develop their own rules because able-bodied sport had to be adapted extensively, if it could be at all, in order for them to participate. There was still segregation however. There were still no moves for any disabled group other than the spinal paralysed to take part in the Stoke Mandeville Games. Guttmann's firm hold on the international representation of disabled sport in Britain would continue for many more years.

Chapter 7

Sporting and Political Pursuits: Disabled People 1960-1970

The 1960s signified a period of change and in some cases unrest, around the world. For disabled people in Britain, the 1960s were a time of changing attitudes toward many aspects of their lives that many of them had taken for granted. It was still not known how many disabled people there were in Britain at that time,[1] but different disabled groups combined in order to protest and demand a better standard of welfare and benefits than they had accepted before. Low levels of unemployment, incomes falling farther behind those of the able-bodied and the preference for the war disabled over other disabled groups were challenged.

Dissatisfaction with the status quo did not express itself solely in the political arena. We shall also examine issues of access and also the tension between the provision of recreation for disabled people and other requirements that they found more important such as aids and adaptations. Not all disabled people found sport and exercise threatening however, and part of the bids for access were in order to attend sporting and recreational clubs. One voluntary society used the lack of provision by government sporting bodies to demonstrate another

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[1] These included 50,00 people with multiple sclerosis, 12, 000 with polio, 100,000 affected by cerebral palsy, 200,000 with disabling injuries of the spine and limbs, and six million affected by arthritis. On a yearly basis, there were 3,500-4,00 amputations performed and 2,000 babies born per year with spina bifida by 1968. Disabled Living Foundation, *Sport and Physical Recreation for the Disabled* (London, 1971), p. 13.

way that the government was failing in its provision for disabled people. With some administrative support, both recreational and competitive sport for disabled people expanded no more so than the Stoke Mandeville Games.

It was obvious at this time that disabled people were becoming less quiescent than they had been, both in demanding greater sporting opportunity but also reminding the government and the public that disabled people had other, possibly more pressing grievances too. One disabled person wrote, 'We are tired of being statistics, causes, wonderfully courageous examples to the world, pitiable objects to stimulate fund-raising'.[2]

Discrepancies in support still existed widely amongst the disabled. Although war pensioners continued to receive cars and other benefits, other disabled people were not as well provided for. One of the most influential was the Disablement Income Group, which was started by two disabled housewives in 1965.[3] They put pressure on the government to call attention to those disabled people who did not qualify under any of the criteria, for a pension with age, war nor industrial injury. Demonstrations were held and disabled people used their Invacars and other vehicles to flood Trafalgar Square in 1967.[4] Throughout the latter part of

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[2] Paul Hunt, *Stigma*, (London, 1966).
[3] For details on DIG see Jane Campbell & Michael Oliver, *Disability Politics*, (London, 1996), pp. 52-61.
[4] BBC News Archives, 30 July 1967.

the 1960s, DIG continued to pressure and protest, and in 1969 presented a petition that demanded a national income for disabled people.[5]

Some politicians attempted to lead this movement for improved provision for disabled people. In 1968, Jack Ashley, the only deaf MP in the House spoke about the discrepancy between those who had received an industrial injury and those who had an advancing disease. He cited a man with multiple sclerosis who was provided with one third of the income of a man who had suffered an industrial injury.[6] In 1968 two bills were defeated in the House of Commons, one aimed at meeting the demands of DIG, the other to appoint an advisory commission that would conduct a review of all benefits provided for disabled people. A Private Members Bill in December 1969 re-opened the debate on welfare for disabled people. Seats were removed in the House of Lords so that disabled members who were in wheelchairs could be at the forefront of the debate. Outside the two Houses, a group of disabled people drove their tricycles from Hyde Park to Westminster.[7] The resulting Chronically Sick and Disabled Persons Act of 1970, expanded the remit of the National Assistance Act and provided disabled people with the hope that the variation in their treatment would be remedied.[8]

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[5] *The Lancet*, (July 5, 1969), p. 63.
[6] Morris and Butler, *No Feet to Drag*, (1972), p. 17.
[7] BBC News Archives, Disabled Drivers Protest, 17 December 1969.
[8] Michael Oliver and Colin Barnes, *Disabled People and Social Policy*, (London, 1998), p. 9.

Although government training centres, which retrained the disabled for work increased in number markedly during the 1960s, there appeared to be few jobs available for the newly trained disabled to take.[9] Indeed there was little wonder that DIG was so concerned about ensuring better support for disabled people. This lack of work was in part the product of a changing economy, but also a result of companies failing to recruit disabled people into the workplace. By 1969, only 46.3% of all companies were employing the requisite percentage of disabled people.[10] It also must be borne in mind that large numbers of disabled people were civilians, so there was no necessity on the part of employers to perform their patriotic duty and hire disabled ex-serviceman. The number of disabled people had reached a climax in 1950 when 900,000 people were on the register, but this had declined to 235,000 by 1969.[11] Despite the downturn in the numbers of disabled people who were employed through the register system, taking a job was still viewed as a positive action. Employment was still one of the ways in which the disabled could integrate with able-bodied society, and many disabled felt that they were entitled to a job and all that went with it. One disabled person wrote,

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[9] Government training centres increased from 13 in 1963 to 46 in 1970. Morris and Butler, No Feet to Drag, (1972), p.59.
[10] *The Lancet*, (May 31, 1969), p. 1102.
[11] Morris and Butler, *No Feet to Drag*, (1972), p.11.

> ...Work is itself leisure and pleasure – often there is no escape, and to work is the only way for us to be useful to and needed by the society in which we live.[12]

> Even though employability is only one function of citizenship it does run in parallel with other aspects of living in the community as something less than a parasite.[13]

The company established to provide jobs for the more seriously disabled, Remploy, was criticised for having insufficient jobs and poor pay.[14] There were other problems with more mainstream factories, for example, a man was sacked after he had gone to the hospital for a check-up. 'To tell any employer in this area that you are a registered disabled person is like signing your own death certificate'.[15]

Trouble with employers was not the only problem that beset disabled people. The Transport difficulties continued to affect them seriously in the 1960s. As we saw in Chapter Five, the National Health Service had provided single seater cars such as the Invacar to the civilian disabled. Ostensibly cars were available to disabled people, but a survey conducted in 1965 by the Greater London

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[12] Denis Creegan, 'Adapt or Succumb', Hunt, (ed.), *Stigma*, (1966), p. 119.
[13] John M.P. Clark, 'Rehabilitation of Cerebral Palsied Children' in *Aspects of Rehabilitation*, (London, 1968), p. 16.
[14] *The Lancet*, (March 21, 1964), p. 659.
[15] Morris and Butler, *No Feet to Drag*, (1972), p. 53.

Association for the Disabled found that only 16% of disabled people had access to one. For those that had a car, some found them particularly difficult to use.

> I had a three-wheel vehicle which I basically didn't want to drive because they never gave you any driving lessons – they just serviced and supplied the vehicles.[16]

Other disabled groups began to demand better provision of transport with miners, who were entitled to the three-wheeled car provided by the Ministry of Health, insisting on the same type of transport as was available for the disabled ex-servicemen.[17] The war wounded were being used as a benchmark for other disabled groups, who found that they were falling far short of what was offered to this privileged section. The government did not capitulate on this issue, but in 1967 three new groups of disabled were given access to real cars as opposed to invalid cars.[18]

These issues were exacerbated by the inadequacies of public transport.

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[16] Campbell and Oliver, *Disability Politics*, (1996), p. 35.
[17] There were 3,400 war wounded entitled to a car. H. Atkinson, 'Motor Cars for Paraplegic Mineworkers', *Rehabilitation*, 42, (July-September 1962) p. 89.
[18] These included a disabled widow or widower with small children, two relatives if one was disabled and one blind, and two relatives in the same household one of whom was so disabled as to not be able to hold a drivers licence. *The Lancet*, (February 25, 1967), p. 455.

> Much of the public transport system could have been designed by a sadistic physical training instructor previously employed on devising assault courses for commandos.[19]

Transport could still be primitive. A disabled people's club whose members were in wheelchairs was loaded into a furniture van in order to attend tea and a concert at the local Cripples Guild.[20]

Mobility was not the only area where disabled people felt they lagged behind the rest of the population. Due to the individual nature of disability, aids and adaptations had to be developed on an individual basis which made them expensive to produce. The technology of the development of aids lagged behind that of medicine. Therefore, while many disabled people were surviving thanks to medical technology, they were not able to make the best of their lives because they lacked the necessary equipment which would have made a difference.[21] One critic went so far as to say that advances in medical science allowed those with severe disabilities to live but then to face 'virtual death' in a society that lacked equipment and aids to assist them.[22] There were complaints that adaptations were unsuitable and disabled people who could afford it had their own made privately, despite the expense.[23] Some charities tried to help; the Red

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[19] Morris and Butler, *No Feet to Drag* (1972), p.77.
[20] Morris and Butler, *No Feet to Drag* (1972), p.86.
[21] This issue is discussed in detail in Kennaway, 'The Development of Equipment for the Disabled', *Aspects of Rehabilitation*, (1968).
[22] Alexander Kennaway, 'The Development of Equipment for the Disabled', *Aspects of Rehabilitation*, (London, 1968), p. 29.
[23] Reginald Ford, 'Quite Intelligent', Hunt (ed.), *Stigma*, (1966), p. 35.

Cross published a book on adaptations.[24] In essence simple adaptations were the only ones that were regularly installed, and the most common aid for disabled people was the portable wooden ramp.[25] Clothes were available under the NHS, but many disabled people did not want the stigma of the unfashionable and simple garments.[26] There were some technologically advanced aids that were produced for disabled people, although their use was not widespread. Called POSSUM[27] the patient could through a series of sucking and blowing on a tube to type letters, turn on the television and perform a host of other functions.[28] It was developed largely for the use of quadriplegics or those who had severe cases of residual paralysis through polio. It is evident that hospitals and voluntary services were adept at developing aids for disabled people but their dissemination was partially or never though experiments on the long cane, conducted in Britain in 1964, were adopted it for the blind.[29]

As well as technological advances in aids, medicine had its share of innovations during the 1960s. Hip replacements had been developed in this decade and heart transplant surgery became a reality in 1967.[30] Rehabilitation remained an

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[24] These aids were at a low level of technological development. The Red Cross booklet suggested that an upturned scrubbing brush made a suitable holder for a hand of cards. *The Lancet*, (June 13, 1964), p. 1337.
[25] Ursula Keeble, *Aids and Adaptations*, (London, 1979), p. 33.
[26] Margaret Gill, 'No Small Miracle', Hunt, (ed.), *Stigma*, (1966), p. 105.
[27] POSSUM came from the Latin verb for 'I am able' and Reg Maling and Deryck Clarkson developed the Patient Operated Selector Mechanism. Paul Bates and John Pellow, *Horizontal Man*, (London, 1964), p. 164.
[28] Work was started in September 1960 and funded by the Poliomyelitis Research Fund. *The Lancet*, (December 8, 1962), p. 1220.
[29] Rose, *Changing Focus*, (1970), p. 97.
[30] Porter, *The Greatest Benefit to Mankind*, (1997), p. 621-623.

important form of therapy, but disabled people began to refuse the type of help that the medical system mainly offered. The physiotherapy that had been so widely used and heralded as a breakthrough in treatment was referred to by some critics as 'an incredible regime of awfulness and torture which they chose to call physiotherapy'.[31]

Provision for rehabilitation peculiar to women in the home was increased during the 1960s, including special units in hospitals which assisted the rehabilitation of housewives. These units involved a series of flats where women could learn to do their domestic chores from a wheelchair.[32]

Developing medical knowledge increased the survival rates of more severely disabled children. A child with spina bifida for instance, had their chance of survival increased from 10% to 50% in the 1960s.[33] Children with multiple disabilities such as learning difficulties and blindness were surviving longer which meant a new set of expensive problems to provide the high level of care required to give these children an acceptable standard of attention into early adulthood.[34]

Of course medical advances involving drugs did not always meet with success. Thalidomide, given to pregnant women to relieve nausea had tragic

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[31] Campbell and Oliver, *Disability Politics*, (1996), p. 31.
[32] *The Lancet*, (July 21, 1969), p. 252.
[33] Morris and Butler, *No Feet to Drag*, (1972), p. 42.
[34] Children were not the only group of disabled, and from 1959 traffic accidents accounted for 40% of amputations, and accidents at work another 40%. The rest was made up of recreational and accidents in the home and those in the Armed Forces. Miroslaw Vitali et al, *Amputations and Prostheses*, (London, 1978), p. 9.

consequences for some children and their parents. Although there were no birth defects attributed to it when it was officially removed from sale in 1961,[35] there had been in other countries. Thalidomide affected the development of the limbs, hearing and brain development in the foetus. Children were born with gross limb deformities, brain damage and deafness. For the first time in British legal history, a group of parents sued the company producing the medication. The legal battle started in 1962 and it was not until 1967 that the company offered to settle.[36] This case contributed to the public campaign which led to the Abortion Act of 1967. Under its terms, a woman could receive an abortion if she was carrying a disabled foetus.[37]

The sixties saw more pressure from disabled people and more political and economic awareness of their grievances. In 1964 the McCorqudale Committee was set up to examine previous legislation for disabled people and also to make recommendations whether or not more money should be paid to those people with amputations who required more care as they got older.[38] The Committee's examination basically supported the status quo, with no new funds allocated to the ageing disabled and a general agreement that what had been recommended previously was acceptable. The only new recommendation was that all leg and

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[35] More controls of drugs were as a result of thalidomide. The Committee on the Safety of Drugs was established in 1963. Berridge, *Health and Society in Britain Since 1939,* 1999.p.30.
[36] The company Distillers offered each child 40% of the total damages the child would be entitled to if the company was successfully sued. A withdrawal of the charge of negligence also had to be made. *The Lancet*, (February 24, 1968), p. 428.
[37] Jones, *Health and Society in Twentieth Century Britain*, (1994), p. 133.
[38] The McCorquodale Committee examined Schedules 1 & 3 of the Royal Warrant 24th May 1949 and Schedule 2 to the National Insurance (Industrial Injuries) (Benefit) regulations 1964, PRO PIN 20/458, Minute of Appointment 3A, 26 October 1964.

arm amputations be assessed at 100% disability.[39] The Committee also recommended that an extra allowance be paid to those who were 'exceptionally' disabled.[40] One of the reasons for this small success may have been due to the fact that the British Legion was lobbying for the increase, and disabled ex-servicemen continued to receive the most benefits.[41] Not until the Chronically Sick and Disabled Persons Act was passed in 1970 were there many major alterations to legislation for disabled people.

While the British Legion continued to press for superior treatment to be provided to those disabled in the war, other agencies continued their work in different ways. One of these was the renaming of certain journals and associations, which removed some of the more demeaning terms applied to disabled people. Although many agencies for disabled people's welfare had been established throughout the 1950s, some amalgamated in the 1960s. These included the National Spastics Society and the British Council for the Welfare of Spastics who joined in 1963, yet the name was not changed immediately.[42] The National Association of Cripples changed its name and also merged with the National Fund for Research into Crippling Diseases.[43] Name changes reflected the new politically active disabled groups. No longer did they want to have names like 'cripples' or 'dumb', but instead wished to have titles that more accurately

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[39] PRO PIN 20/458 Report of the McCorquodale Committee to the Minister of Pensions and National Insurance Margaret Herbison, 1964.
[40] *The Lancet*, January 1, (1966), p. 55.
[41] Brown, *Red for Remembrance*, (1971), p. 105.
[42] Dimbleby, *Every Eight Hours* (1964), p.32.
[43] *The Times* (August 22, 1968).

depicted disabled people as people, and not merely objects of pity with labels. As one disabled person remarked about the term cripple, 'It is clearly not a word suited to the vocabulary if the 1960s'.[44] Identifying disabled people positively spread, as local associations changed their names. In 1964 the Leicester Guild of Cripples was changed to the Leicester Guild of the Physically Handicapped.[45]

In 1964 and for the second time running the International Stoke Mandeville Games were held in the same city as the Olympics. The Japanese supported the event, with attendance records set of 100,000.[46] Despite this, and the fact that the British team had some success at the Games in Tokyo taking home 21 gold 27 silver and 23 bronze medals,[47] there was not a great deal of publicity for the disabled games in Britain, either during or after the event. A Foreign Office Report concluded, 'It was difficult to devote much time or thought to the Paralympics when all was dominated by the Olympics.'[48]

The able-bodied Games were of such importance that the departing able-bodied athletes did not know that their disabled compatriots would be using the facilities of the Olympic Village after them.

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[44] Ford, 'Quite Intelligent', Hunt, (ed.), *Stigma*, (1966), p. 32.
[45] Seaton, *From Strength to Strength* (1998), p.79.
[46] Guttmann, *Textbook of Sport for the Disabled*, (1976), p. 27.
[47] PRO MH 99/83 Letter from J. Fish to R.G.S. Hoare, Chief Information Officer Ministry of Pensions and National Insurance, 6 May 1965.
[48] PRO FO 371/181107 Olympic Games, Summary Tokyo 1964.

It cannot be very pleasant for the newcomers to notice here and there signs of hooliganism such as the mess made by fire extinguishers let off by members of the Olympic teams on their last night. Our people included a few individuals who were rather overexuberant in this and similar ways, but who might have been more restrained if they had realised their actions were likely to affect the amenities of their successors.[49]

Guttmann actually complained about the lack of press coverage for the Stoke Mandeville Games as a sporting competition in its own right[50], and is quoted in *The Guardian* saying,

> It is obvious it still considers the Stoke Mandeville Games as news and not as sport as it should be. This is contrary to the attitude of the press in other countries.[51]

This was evidence that Guttmann believed that sport for paralysed people was a sporting activity in its own right. While still providing a vital role in rehabilitative therapy, sport for disabled people could also be something pursued for itself. For those who had gained fitness, sport could be played at a higher level than the

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[49] Ibid.

[50] *The Manchester Guardian* covered the prelude to the Stoke Mandeville Games twice on November 4 & 5, 1964. There was no reporting of results during the Games. *Sport and Recreation*, the Quarterly Journal of the CCPR did not provide any coverage of the Games either.

[51] *The Manchester Guardian*, (November 23, 1964).

purely recreational or the maintenance of fitness in a competitive framework similar to that of able-bodied athletes.

Despite the lack of press coverage of events in Tokyo, when the athletes came home they received government recognition for their success at a reception held at Downing Street for 300 guests.[52] The Prime Minister, Harold Wilson was in attendance and met with the athletes. Sport was obviously not the only topic discussed at the reception as the Prime Minister later wrote to the Minister of Pensions asking what facilities and benefits were provided for paraplegics, and what improvements could be made should more money be available.[53] Despite such potentially positive steps, the very make up of the disabled community was changing. Whereas earlier sporting competitions had been dominated by the war disabled, the number of war pensioners participating in the events was bound to diminish. In Tokyo, only 19 of the total of 70 competitors had received their injury as a result of war.[54] But this piece of prime Ministerial intervention does not appear to have been followed up.

It was Harold Wilson who again spoke at the second reception held for the competitors who had returned from Israel in December 1968.[55] The Stoke Mandeville Games had been held there as Mexico, the site of the able-bodied

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[52] It cost £300. PRO MH 160/376 Letter to Mr Pater from A.W. France, 30 November 1964.
[53] The reply explained the benefits including the provision of cars and motorised wheelchairs, aids and adaptation in homes, such as ramps and rails. PRO MH 160/376, Memo to the Prime Minister from the Minister of Pensions and National Insurance, 14 January 1965.
[54] PRO MH 160/376 Letter from J. Fish to R.G.S. Hoare, Chief Information Officer Ministry of Pensions and National Insurance, 6th May 1965.
[55] *The Cord*, Vol. 20, No. 4, (Winter 1968/69), p. 13.

Olympics, was unable to accommodate disabled competitors. The reception, which the competitors, government officials and some television stars attended, gave some further publicity to the International Stoke Mandeville Games.

Sporting competition for disabled people continued to grow throughout the 1960s. New international events were established for the spinal injured when the first Commonwealth Paraplegic Games were held in Perth, Australia in 1962. The events were the same as those held at the Stoke Mandeville Games, but like the able-bodied event of the same name, entry was limited to Commonwealth countries.[56] This time the events were held prior to the Commonwealth Games proper and some venues, including the swimming pool, were used by both types of competitor. As so often had been the case, experiments were conducted during this new experience. The long flight to Australia provided an opportunity for Guttmann to test fluid retention in paralysed patients, as helpers were given measuring tapes to regularly measure the ankles of the paraplegics on the plane.[57] The Commonwealth Paraplegic Games continued in Jamaica in 1966, and Edinburgh in 1970.[58] While the numbers of participant countries increased to fifteen in 1970, the Commonwealth Games for the Paralysed staged their last event in Dunedin, New Zealand in 1974 at the same time as the able-bodied

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[56] Nine countries competed including Australia, New Zealand, India, England, Northern Ireland, Rhodesia, Scotland, Singapore and Wales.
[57] Scruton, *Stoke Mandeville*, (1998), p. 170.
[58] Guttmann, *Textbook of Sport for the Disabled*, (1976), p. 32.

games were held.[59] There were several reasons offered for this, the most pressing probably being a lack of funds.[60]

Throughout the history of games for disabled people in Britain, different groups had kept their activities separate, for instance Stoke Mandeville had always represented the interests of those with spinal paralysis. This was changed radically in 1961, when there began to be some co-operation between several disabled groups. In late December 1960 the Stoke Mandeville Games Committee joined with BLESMA, the British Council for the Welfare of Spastics, the Disabled Drivers Motor Club, the Invalid Tricycle Association and the Pony Riding for the Disabled Trust to form the British Sports Association for the Disabled. BSAD's main purpose was to organise and co-ordinate sporting events for disabled people. While representing a conglomeration of sporting interests, this did not mean that there was to be any co-operation in the problems outside sport.[61] BSAD's first event was a Sports Day for amputees, held in June 1961. Not all disabled groups were originally included, although some joined in the years following its establishment, for instance, St Dunstan's, the British Polio

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[59] The Irish paraplegic team went to watch their heroine, pentathlete Mary Peters compete in her last Commonwealth Games. Peters recalled, 'They were bubbling with fun and so happy for me that I almost had to force myself to realise that every one of these people had been stricken with a deep personal tragedy.' Mary Peters & Ian Wooldridge, *Mary P. Autobiography*, (London, 1974), p. 139.

[60] It was decided by the Commonwealth Games Committee to opt for World Zone Games such as the Pan-American Games after 1974. Scruton, *Stoke Mandeville*, (1998), p. 178. Marilee Weisman & Jan Godfrey, *So Get On With It: A Celebration of Wheelchair Sports*, (Ontario, 1976), p. xiii.

[61] Scruton, *Stoke Mandeville*, (1998), p. 108.

Fellowship and the Society for One-Armed Golfers became members in 1962.[62] Although there were opportunities for other types of disabilities to organise and participate in their own events using facilities at Stoke Mandeville, there was no question of them participating in the Games. These remained what those at Stoke Mandeville called 'pure', meaning there were no events for any other competitors than those with spinal injuries.

Stoke Mandeville had control over the BSAD as Guttmann was Chairman and other employees from there took up key positions, for example, Guttmann's secretary Joan Scruton was Honorary Secretary/Treasurer. When the government established their own Sports Council in 1965,[63] it was the BSAD that was recognised with and the CCPR as the co-ordinating body for all disabled sports in Britain. Among other things this meant that BSAD was entitled to government grants in order to promote disabled sport. This availability of funding may be one of the reasons why there were so many different sporting competitions held within the latter part of the 1960s. In 1967 there were games for disabled children, and in 1968 there was enough interest to have a junior and a senior competition. The first national Sports Day for those with polio was held on August 17th 1968 in Birmingham.[64] A year later, the first national riding competition for disabled people was held at Stoke Mandeville, although demonstration of this therapy had been shown at horse shows and the Stoke

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[62] By 1970 BSAD had 56 members within its organisation. Disabled Living Foundation, *Sport and Physical Recreation for the Disabled*, (1971), p. 7.
[63] Holt, *Sport and the British*, (1992), p. 344.
[64] North, *Something to Lean On* (1999), p.74.

Mandeville Games much earlier.[65] In that same year, the Queen opened a new sports stadium there.[66] This sports hall provided protection from inclement weather, and was financed by public subscription and donations. The number of sporting competitions for disabled people increased during the 1960s and by 1970 there were fourteen different sporting events between May and October.[67] Disabled sport in Britain was beginning to shed its mantle of being small-scale, isolated and lacking in government support, and instead demonstrated a varied number of competitions most of whom were supported in some way by the State.

Throughout the 1960s, the Stoke Mandeville Games continued to be held in England every year, a well as the international competitions at Olympic venues in the Olympic years. New events were constantly explored throughout the 1960s, for example, and in 1961 both weightlifting and lawn bowls were exhibition games at Stoke Mandeville.[68] By 1968 there were thirty-three events for both men and women at the National Games, which spread over four days.[69] Internationally, the Stoke Mandeville Games continued to inspire new sporting competitions for disabled people. In 1967, the first disabled version of the Pan-American Games was held.[70] Those with spinal injury were not the only group

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[65] The demonstration at Stoke Mandeville was in 1962 and in 1965 riding for disabled people was performed at the Horse of the Year Show. Riding for the Disabled Association, *The Spirit of RDA*, (1995), p. 30 & 33.
[66] BBC News Archives, August 2, 1969.
[67] These included the Junior Multi-disabled Games, the Pinderfields Paraplegic Games, the Oswestry Paraplegic Games and the BLESMA Northern Games. *The Cord*, Vol. 21, no. 4, (Winter 1969/70), p. 16.
[68] Guttmann had seen a paralysed weightlifting competition in 1956 in Perth, Australia. Scruton, *Stoke Mandeville*, (1998), p. 83 & 92.
[69] *The Cord*, Vol. 20, No. 3, (Autumn 1968), pp. 25-33.
[70] Savitz, *Wheelchair Champions*, (1978), p. 64.

whose games had an international flavour. The blind members of St Dunstan's had their first international sports competition in 1968 with athletes from Austria, France, West Germany and Poland. The range of events included sports from sprinting to rifle shooting.[71]

Organised paraplegic sport was growing, but as it was promoted and came under more scrutiny, so it attracted more controversy. In 1965 the International Olympic Committee raised objections to the term 'Paralympic' which had been used to describe the games.[72] The International Stoke Mandeville Games Committee was happy to accede to the request on behalf of the IOC as they felt it would be more fitting to be reminded where the games had originally taken place, than change the title of the event completely. Paralympics continued to be used as a casual reference, but it was not until the 1980s that the IOC gave permission for the term to be used.[73]

The relationship between sport and exercise began to change in the 1960s. As we have seen in previous chapters remedial exercise provided by trained physiotherapists was the most important facet of rehabilitation. Although it cannot be denied that sport and games were an integral part of Stoke Mandeville's regime, sport was an activity that the patients worked toward, after completing hours of physiotherapy. The Spinal Unit's physiotherapy department

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[71] *St Dunstan's Review*, Vol. 54, No. 590, (1968), p. 10.
[72] The term 'Paralympics' was not used officially until 1984. Scruton, *Stoke Mandeville*, (1998), p. 307.
[73] Scruton, *Stoke Mandeville*, (1998), p. 102.

became a model for others and many student physiotherapists went to Stoke Mandeville to learn their techniques. Not all patients were enthusiastic about playing games and sport, and participated in the remedial exercise programme in order to return to health. Patients with paralysis were not the only disabled group that benefited from movement therapy, such an important part of rehabilitation. Physical therapy became an important part of the regime for those people with cerebral palsy.

> Children who cannot run or walk can slither, slide, wriggle, roll, push or pull themselves along a flat surface and often up and over objects successfully.[74]

Doctors also took more of an interest in sport for disabled people during the 1960s precisely because of its non-rhythmic compound movements of the spine.[75] Sport began to change from a merely rehabilitative type of medical practise to fulfilling different types of functions for different types of disabled people. Sport as therapy in a medical environment had remained tied together as is evidenced by Guttmann's strong connection with disabled sporting associations and his medical practise. Contemporary notions stressed this idea.

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[74] Myfanwy Dewey, 'The Physical Education of the Cerebrally Palsied', *Spastics Quarterly*, Vol. 12, No. 3, (September 1963), p. 52.
[75] Williams, *Medical Aspects of Sport and Physical Fitness*, (1965), p. 179.

> It is perhaps time for us to realise that physical rehabilitation and corrective therapy may best be carried out solely by the professions most closely allied to medicine and surgery.[76]

Alongside the advance of organised and competitive sport, the 1960s witnessed the development of a series of other recreational and leisure activities, as well as an awareness of their value by representative bodies, that would benefit disabled people and further advance their physical and social welfare.

> They (sport and games) are primarily the occupational therapy of the mind and the spirit and can do much to build a whole personality in a maimed body.[77]

While many disabled people had neither the interest nor the ability to compete in the International Stoke Mandeville Games, there were a number of those who enjoyed recreation whether it was sport or something more sedentary. The Disabled Living Foundation concluded that disabled people were not being provided with a sufficient amount of opportunity to practise sport or recreation.[78] Despite the existence of groups such as BSAD, disabled people were still on the margins when it came to sporting participation. Disabled sport had begun to be

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[76] Dudley F. Cooper, 'The Physical Education Specialist in the Community: the Handicapped', *The Leaflet*, Vol. 67, No. 1, (January-February 1966), p. 28.
[77] Kershaw, *Handicapped Children*, (1961), p. 43.
[78] Morris and Butler, *No Feet to Drag*, (1972.), p. 108.

divided into two types, what was termed the 'competitive' and the 'personal'.[79] Those who were of a high standard and competed in events such as the Stoke Mandeville Games had reached the field of competitive sport, and those who practised sport for their own enjoyment or as part of a fitness regime were the personal. The competitive needs seemed to be met, but what about the personal aims of disabled people? In order that this deficiency was redressed, the Disabled Living Activities Group started several projects. In 1961, a private donor gave funds so that disabled people outside Stoke Mandeville and its affiliates could learn archery, and in 1963 gardens were established at Mt Vernon Hospital and Nuffield Orthopaedic Centre for the less active to enjoy gardening.[80] While these may have been small scale, in 1967 a much larger undertaking called Physical Recreation for the Disabled was started.[81] Seventeen different agencies including government departments, such as the Ministry of Health and large charities like the British Red Cross were on the panel of experts, for the project, which advised on different projects.[82] The terms of reference were agreed by the panel members and were,

> To investigate the existing participation in recreational activities, with particular reference to physical recreation, by the disabled; and in the light of the findings, to pursue means of extending this participation.[83]

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[79] Kershaw, *Handicapped Children* (1961), p.39.
[80] Anderson, *A Record of Fifty Year's Service*, (1969), p. 50.
[81] *The Voice of the Disabled*, No. 151, (1969) p. 7.
[82] Ludwig Guttmann was a member of the panel. Anderson, *A Record of Fifty Years Service*, (1969), p. 50.
[83] The blind and deaf were excluded from the enquiry. Disabled Living Foundation, *Sport and Physical Recreation for the Disabled*, (London, 1971), p. i.

Problems that confronted disabled people included access to both sporting programmes and venues, and aids designed to assist in participation. Like the Wolfenden enquiry, questionnaires were sent to national sporting bodies, national associations for disabled people and youth voluntary organisations and colleges.[84] Funding for the different projects which included equipment design, and access to buildings was provided by donation, money from the Central Council for the Care of Cripples and grant assistance.[85] There were some aids especially designed to assist disabled people to practise sport, which included special waterproof coverings for artificial limbs for swimming.[86] Disabled people did not want to be isolated in their own sporting or leisure clubs, but wanted instead to move freely throughout the community and this meant in the sporting arena as well. One woman with polio remarked that it was 'odd that people are expected to enjoy being together merely because they are all incapacitated.'[87] Medical practitioners agreed that it was important for the disabled to mix with those who were 'normal'.[88] As disabled people wanted to attend the same sporting venues as the able-bodied, so they also wanted to gain equal access to their local sporting centres. There was not much point in being allowed to use a sports centre if they could not use the toilet while there because it was not large enough to admit a wheelchair or an attendant.

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[84] Disabled Living Foundation, *Sport and Physical Recreation for the Disabled*, (1971), p. 2.
[85] 'Physical Recreation for the Disabled', *The Leaflet*, Vol. 69, No. 10, (December 1968), p. 85.
[86] Morris and Butler, *No Feet to Drag*, (1972), p. 107.
[87] Rosalind Chalmers, 'Victim Invicta', in Hunt, *Stigma*, (1966). p.25.
[88] Kershaw, *Handicapped Children*, (1961), p. 43.

How did the able-bodied sporting associations respond to these pressures from sporting disabled people? In 1966, Sport for All, the government programme that was supposed to provide facilities and opportunities for the whole nation to play recreative sport was set up. Unfortunately, none of the sports bodies involved such as the Sports Council, the CCPR or its Scottish counterpart the SCPR had thought seriously about providing sport for disabled people.[89] On the whole, disabled people were largely excluded from Sport for All.[90]

Access for disabled people developed into a big issue and sport was one of the locations. This was not just the inability to get into public sporting arenas, but other fundamental activities that the able-bodied took for granted. Recognising this need, guide books for the disabled began to be printed in 1969. In 1963, the Central Council for the Care of Cripples appealed to churches to take some action for the disabled who were unable to gain access to worship, or witness a wedding or attend a christening.[91]

For those disabled people for whom leisure and activities were not important, some felt that recreation for disabled people was a way to avoid assisting them in more meaningful ways. It was felt that there was a heavier emphasis by the State on clubs and recreational facilities and less money was being spent on aids

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[89] Disabled Living Foundation, *Sport and Physical Recreation for the Disabled*, (1971), p. 9.
[90] The CCPR did involve itself in riding for the disabled. Horse riding for the disabled was increasing in popularity and the Riding for the Disabled Association was set up in 1969 with Princess Anne who had a strong association with horse riding as the President. Vanessa Britton, *Riding for the Disabled*, (London, 1991), p. 13.
[91] Anderson, *A Record of Fifty Years Service*, (1969), p. 52.

and benefits for disabled people.[92] One woman suggested that the authorities should spend 'more in trying to supply temporary helpers and gadgets instead of concentrating so much on parties and pantomime trips'.[93] Some disabled people felt unhappy with the amount of time that the able-bodied spent on keeping fit. One disabled man wrote about the sporting able-bodied and disabled people who were housebound.

> They become bitter when they see the amount of energy that is being dissipated in, for example 'keeping fit' for sport and games, which, they consider, might occasionally be used to give them an airing. Keep-fitters might well include in their training programme pushing a chair for a few miles.[94]

Clearly the 1960s were a period of change for many disabled people. As a group their composition was changing, as the numbers of war veterans diminished, and new treatments effectively reduced the number as did . Numbers of disabled civilians was a growing in terms of the percentage of disabled people in Britain. Disabled people no longer accepted the idea that of the war disabled should have preferential treatment. Disabled people became more politically aware and formed new protest groups who were prepared to take their campaign to the streets as well as Parliament and the media in order that their voices would be

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[92] Keeble, *Aids and Adaptations*, (1979), p. 33.
[93] Chalmers, Victim Invicta, in Hunt, *Stigma*, (1966), p.25.
[94] Ford, 'Quite Intelligent', in Hunt, *Stigma*, (1966), p. 38.

heard. In some cases, disabled people frowned upon the provision of recreation because some believed that it was the State's cheaper option. However, recreation and sport were tied into issues of access and availability, and voluntary associations tried to ensure that mass recreation was not another activity that disabled people would be unable to take part in. A minority enjoyed representing their country at the International Stoke Mandeville Games, and an increased number of disabled people were enjoying competitive sport under the umbrella of BSAD.

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Chapter 8

A Separate Life: Deaf Sport 1924 – 1970.

Although deaf people have been mentioned throughout the thesis, they deserve their own chapter because of the uniqueness of their experience. What separated them from the able-bodied also segregated them from other disabled groups. And one of the factors which made the deaf different from other disabled groups, and is important here, were their sporting exploits. Deaf people were able to establish their own international sporting association, without much assistance from the able-bodied, quite distinct and separate from other disabled groups. Unlike other disabled people, whose discovery of exercise and sport was largely as a result of a period of rehabilitation, deaf people played sport and games without any medical control. The chapter will explore the reasons behind their isolated and autonomous existence within the sporting arena. In doing so, we hope to illuminate the complex relationships that have existed between different disabled groups, and show how deaf people were able to duplicate able-bodied sporting practices.

The reality of deaf separateness had complex causes. Often deafness was not as obvious as some other types of disability. A deaf person had no outward signs of difference. There was no empty sleeve, nor a wheelchair nor a white cane which labelled them as disabled. Historically, due to the inability of deaf people to communicate along the accepted norms of speech and hearing, they

were often considered mentally subnormal, and were subject to a failure of understanding from able-bodied people. It was stated that 'deaf-mutes formed a separate community, almost a distinct variety of *Homo sapiens*'.[1] This statement is very apt, as deaf people were segregated from the able-bodied by the very nature of their condition, and also in some cases, not afforded the same consideration as other disabled groups, particularly when compared to the other main sensory deprived group of blind people. Even as late as the 1940s, deafness remained a poorly understood disability. The *British Medical Journal* reported a meeting of the Section of Otology of the Royal Society of Medicine in 1941 where it was concluded that:

> Most deaf-mutes were from the outset not quite normal people, showing abnormalities of the central nervous system in addition to the congenital hearing defect.[2]

Some contemporary representatives of authorities disagreed, 'fewer deaf people would lose their graces if hearing people befriended them with constancy and sympathy and treated them as rational beings.'[3] By 1950 deaf people and their representative bodies still felt that they were misunderstood. Dr Charles Hill of the NID said able-bodied people had not recognised how severe a disability

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[1] *British Medical Journal*, (February 22, 1941), p. 289.
[2] Ibid, p. 289.
[3] *The Manchester Guardian*, (January 31, 1944).

deafness was. He added 'it was not to the public mind as dramatically moving as some other disablements'.[4]

As well as a lack of understanding from the general public, deaf people also lagged behind in assistance provided by the State. Deaf people were not given the same legislative benefits afforded to blind people, there was no equivalent for them of the Blind Persons Act of 1920, nor was there an advisory committee on their welfare as existed for blind people. Optional powers were given to county councils to provide grants in order to place deaf people in local industry under the Poor Law Act of 1930, but spending money in this way was not high on the list of priorities of many of these bodies.[5] There was no compulsory registration of deaf people so there was no clear indication of how many of them there actually were.

Deaf people were divided into two distinct groups. There were those who were referred to as deaf, or before the 1940s as deaf and dumb, by which it was understood that they possessed no form of hearing at all, and their deafness was either congenital or had occurred at a very young age before they were able to speak. The other group was referred to as deafened, and they were those who had lost their hearing some time after birth. This second group would have acquired speech when they were younger, which was very important to their education. Deafness was caused by a number of different diseases and

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[4] *British Medical Journal*, (July 15, 1950), p. 176.
[5] In 1933, Circular 1337 urged county councils to be responsible for deaf people in their locality, but this went largely ignored. National Institute of the Deaf, *All About the Deaf*, (1939), p. 24.

conditions, including measles, scarlet fever and influenza, which all carried with them the chance of residual deafness after the disease had passed. Parents with syphilis could produce deafness in any children born to them. Other causes of deafness included working for long periods of time around loud noise with no safety protection, or in the case of soldiers, being too close to exploding shells. As with so many other types of disability, the First World War increased the number of deaf people, as soldiers experienced ear trauma from explosions and head injury. There were 33,822 cases of deafness in the immediate aftermath of the war.[6] The Ministry of Pensions oversaw the general welfare of the deaf ex-servicemen, providing employment training and instruction in lip-reading.[7] Unusually for a group of disabled people, issues of both heredity as well as poverty were considered important. After the war the familiar combination of poverty and sickness continued to contribute to deafness in the young. In 1936, 70, 000 out of 250,000 Scottish children examined by health inspectors had defects of the ear, throat and nose, and 2,000 had discharging ears 'which might have grave consequences'.[8] In 1939, a study undertaken by specialists demonstrated that four times as many poorer children had middle ear infections that could cause complications later then those who came from wealthier families.[9] The links between poverty and disablement were clearly established, but the issue of heredity was also thought important for deaf people. The

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[6] Ibid., p. 119.
[7] Patrick Beaver, A Tower of Strength, (London, 1992), p. 139.
[8] *The British Medical Journal*, (October 23, 1937), p. 823.
[9] *The Lancet*, (October 7, 1939), p. 785.

National Institute for the Deaf's handbook *All About the Deaf* included some remarks on heredity.

> We should tell the deaf born that they should not marry one another, and we should tell the deaf and the hearing who belong to deaf families that they should marry only into families in which no case of hereditary deafness is known.[10]

Deaf people had their own organisation by 1911 which was called the National Bureau for Promoting the General Welfare of the Deaf, and was founded by a deaf merchant banker, Leo Bonn. Again like the blind, they had their own magazine called *The Deaf Quarterly News*, which commenced publication in 1905.[11] Despite a change in the regulations of the Mental Deficiency Act from 1915-1917 to prevent deaf people being certified as suffering from learning difficulties.[12] The First World War curtailed its activities, but by 1923 the organisation was reconstituted as the National Institute for the Deaf[13] and began a new journal, *The Silent World*, from 1924. The NIB's main functions were the prevention of deafness, and for those already deaf to provide education, employment and care of their social and spiritual welfare.[14] As a charity, the NIB

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[10] NIB, *All About the Deaf*, (1939), p. 29.
[11] The blind commenced publication of *The Braille Review*, now called *The New Beacon* in 1903, although there was a magazine published in Braille type in 1881 called *Progress*. National Institute of the Blind, *Reports 1946-1951*.
[12] McLoughlin, *A History of the Education of the Deaf in England* (1987), p.47.
[13] In 1961, the word 'Royal' was included in the title.
[14] National Institute of the Deaf, *All About the Deaf*, (London, 1939), p. 6.

also took part in 'The Week's Good Cause' in order to raise funds.[15] More organisations were set up during the 1930s and 1940s including the Central Club for the Deafened[16] and the Deaf Children's Society, which was aimed specifically at the parents of deaf children to promote both the interests of the children and encourage co-operation amongst the parents.[17]

Schools for deaf children had been established in Britain since the late eighteenth century. Over 100 years later, the education of deaf children was still an issue, and for many 'the history of deafness is the history of the education of the deaf'.[18] Children were allowed to start school at seven and this starting age was lowered to five in 1937,[19] and the segregation of deaf and hard of hearing children was also implemented in this Act.[20] Like blind children, deaf children remained at school until they were sixteen. As we have already noted, deafness lagged behind blindness in terms of its acceptability and the assistance it received. Schools for deaf children did not enjoy the same level of legislative protection as those for the blind.[21] Whilst blind children could attend grammar

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[15] In 1929 and 1934 raised almost £600, and in 1946 the NIB received £2,530. *The Silent World*, Vol. 1, No. 3, (September 1946), p. 68.
[16] In 1946 its name was changed to the London League for the Hard of Hearing. *The Silent World*, Vol. 1, No. 11, (May 1947), p. 349.
[17] Ewing, *Opportunity and the Deaf Child*, (1947), p. 125.
[18] D. Wright, *Deafness: A Personal Account*, (London, 1969), p. 133.
[19] Beaver, *A Tower of Strength*, (1992), p. 148.
[20] McLoughlin, *A History of the Education of the Deaf in England*, (1987), p. 48.
[21] There was an Education Act (Blind and Deaf Children) in 1893, which gave the responsibility to local authorities to provide facilities, but there was no equivalent to the Blind Persons Act of 1920, and during the twentieth century the difference between the two sensory deprivations became more apparent. Shelia Smith, *Still Unique After All These Years*, (London, 1995), p. 8.

school from 1917, deaf pupils had to wait until 1926 when the Mary Hare Grammar School for the Deaf opened.[22]

The different methods of deaf communication, signing as against oralism, which we have mentioned earlier, provoked divisions within the teaching and in the deaf community itself. The main issue was the arguments for and against the use of sign language. Controversy arose from the choice of two methods, the oral or lip reading method, by which a child was taught speech, and the manual or signing system. In Britain, unlike the United States, lip-reading was the preferred method for communication with the deaf,[23] but more often a combination of the two was used, the only country to do so. There was never an official adoption of either the oral or signing method in Britain, which added to the difficulty of establishing proper norms.[24] There seem to be two explanations for this. One was that the combination method was an active choice[25] and the other that no decision to teach between the oral and manual method was ever made.[26] While deaf educationalists in Britain tended to prefer the oral method for the more advanced child, signing was reserved for those children who found the oral system too hard to learn, or for those who had learning difficulty.[27] The division between profoundly deaf people and the hard of hearing was widened in 1934 by the establishment of the Spurs Club for the heard of hearing. Members were banned

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[22] Pritchard, *Education and the Handicapped*, (1983), p. 201.
[23] McLoughlin, *A History of the Education of the Deaf,* (1987), p. 26.
[24] Ibid, p. 26.
[25] Beaver, *A Tower of Strength*, (1992), p.
[26] McLoughlin, *A History of the Education of the Deaf* , (1987), p. 26.
[27] Doreen E. Woodford, *Homerton 1900-1921*, (Middlesex, 1998), p. 35.

from using sign language or the finger alphabet.[28] Signing was also strictly forbidden at some schools,[29] and children were sometimes disciplined for having the temerity to sign.[30] As late as 1959, the preference for the oral method was evident. The London County Council admitted deaf children under five years old for two hours a day, where 'the staff will give them special attention by talking to them.'[31]

By the 1920s electrical aids were being provided in some schools for deaf children to assist hearing. Hearing aids, though, were another controversial subject, in part because they did not help all deaf people. They were also not supplied free of charge and were costly for an individual to buy.[32] Ex-servicemen received hearing aids free of charge, of course, but civilians and the industrial disabled did not. During the Second World War there were specifications drawn up for a standard model which could be sold at an affordable price.[33] About 15,500 were deafened by the Second World War.[34] The difficulty with aids was not only the prohibitive price, but also their size and the reluctance of deaf people to wear them. The NHS made a big difference to deaf people as for the first time Medresco hearing aids were free and available. Moreover, free medical care meant that a doctor was more likely to see children with complaints such as

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[28] Wright, *Deafness: A Personal Account*, (1969), p. 107.
[29] *The Silent World*, Vol. 1, No. 6, (December 1946), p. 175.
[30] In 1931 a child was punished at the Blanche Nevile School for the Deaf for 'indecent signing'. Smith, *Still Unique After All These Years*, (1995), p. 55.
[31] *The Lancet*, (February 7, 1959), p. 321.
[32] The average cost of a hearing aid was between £18 and £25. *The Lancet*, (July 15, 1944), p. 86.
[33] *The Lancet*, (December 2, 1944), p. 737.
[34] *The Lancet*, (April 6, 1946), p. 522.

discharging ears and make an early diagnosis and prescribe treatment which could avoid later problems.

Deaf people did not require rehabilitation in the accepted sense. They did require training and mechanical aids. While deafened ex-servicemen were provided with lip-reading courses and deaf children were educated, there were no other moves to help deaf people back into society and improve their self-confidence. As for remedial exercises to promote balance and other facets of the rehabilitative process including physical therapy, these were also absent. Rehabilitation for deaf people came in the provision of aids and speech therapy and was provided at a string of major centres in Britain.[35]

Despite the authorities ambivalence toward their rehabilitation, exercise and games were part of many deaf people's lives and sport was both a social outlet and a competitive one. In 1918 Arthur Wilson, a deaf businessman, had formed the Federation of London Deaf Clubs to promote a series of competitions, especially concentrating on outdoor games.[36] From 1920 until 1950 there were ten clubs in the London League, and events included cycling, golf and tennis.[37] Arthur Wilson was a key figure in establishing both the FLDC and other sporting

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[35] These included Manchester and some London hospitals. *The Lancet*, (February 24, 1945), p. 257 & 261.
[36] 'Federation of London Deaf Clubs', *The Silent World*, (November 1924), p. 43. For biographical details, see Arthur F. Dimmock, *Arthur James Wilson 1858-1945*, (Edinburgh, 1996).
[37] Arthur F. Dimmock, 'Sport and Deaf People (Great Britain)', in Taylor and Bishop (eds.) *Being Deaf*, (London, 1991), p. 192.

events for deaf people, providing among others for golf, tennis and football, and the silver Wilson Trophy for billiards.[38]

While deaf people in London were organised into quasi-official competitions, deaf people elsewhere participated in their own individual activities. Some of them were long standing events, for instance, a walking race over seven miles was held annually from Hull to Beverley from 1914.[39] Its purpose was to mark the anniversary of the death of St John of Beverley, Patron Saint of the Deaf.[40] As time went on, and cars became more frequent users of the road, the deaf participants were compelled to wear badges 'to warn motorists of their affliction'.[41]

Deaf people enjoyed a variety of other games and activities, and many able-bodied sports only required minor alterations to be suitable for them to play. Cricket, for example was enjoyed by the deaf, and was played both socially and on a more competitive basis, including at Inter-County Cricket level. *The Manchester Guardian* noted the Lancashire against Yorkshire match at Old Trafford in 1934,[42] remarking that, 'though the play was necessarily silent it only differed from a normal encounter in the absence of vocal appeals and

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[38] Dimmock, *Arthur James Wilson 1858-1945*, (1996), p. 13.
[39] There is no precise date when the race was abandoned, as the last recorded mention was 1955, so it took place for at least 40 years.
[40] The reason for this notoriety was that St John, while Bishop of Hexham, took a deaf boy into his home and taught the boy to speak. He is credited with being the first person to provide education for the deaf. He died in 721. *The British Deaf News*, Vol. 1, No. 4, (July-August 1955), p. 106.
[41] *The British Deaf Times*, Vol. XXVII No. 319-320, (July-Aug 1930), p. 93.
[42] This competition was held from the 1920s. *Deaf Quarterly News* (July-September, 1932), p. 2.

applause.'[43] But it was not until 1930 that the British Deaf Amateur Sports Association was established, in an effort to promote deaf sport.[44]

Outside Britain, deaf sport became international very rapidly, especially when compared to other forms of organised disabled sport.[45] In 1924 the Comite des Sports Silencieux (CISS) was formed in Paris. With members drawn from Britain, Sweden, Germany, France, Belgium and Denmark. The organisation continued to expand and the Europeans lost their stranglehold on deaf sport when both the United States and Japan were accepted for membership of the Association of the Silent World in 1935.[46]

Not only was the CISS established in 1924, but the first international sporting games were held in the same year.[47] Called the International Silent Sports, they were held in the Pershing Stadium in Paris in August, where nine nations vied for sporting glory. Although no numbers were available, the crowds were reported as 'large'.[48] Britain was very successful at these first games, winning the men's tennis doubles, the swimming relay and the football competition.[49]

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[43] *The Manchester Guardian*, (June 18, 1934).
[44] Grant, *The Deaf Advance*, (1990), p. 142.
[45] The International Stoke Mandeville Games did not have an international Games committee until 1960. Scruton, *Stoke Mandeville*, (1998), p. 181.
[46] *The Times*, (September 3,1935).
[47] There was a forerunner to these Games, which had been held in Norway since 1905. *The Manchester Guardian*, (August 20, 1935).
[48] There are no details on actual numbers.
[49] Jackson, *Britain's Deaf Heritage*, (1990), p. 309.

The International Silent Games followed the model of the Olympics, and were held every four years. But unlike the Olympics, women were included from the outset, although the number of events offered to them was less than that for the men. Similar to the efforts of Guttmann at Stoke Mandeville twenty-six years later, the organisers of the games for deaf people had appropriated many of the ceremonial aspects of the able bodied Olympics. All of the teams marched by country carrying their national flag, past a saluting base, which was followed by the reading of the Olympic Oath.[50] In later years, other aspects of Olympic competition were adopted including the medal table. The Deaf have had a system of world records since 1932.[51]

In 1935, the Silent Games were awarded to Britain and were held in London. Although Britain had not disgraced itself at the first three international games, the results were not outstanding. It was generally understood that it was difficult to get competitors to leave home for some weeks, probably due to the fact that most of the athletes had to pay their own fares and lose time off work. This obviously meant that the best team could not always be fielded. When the 1935 Games were awarded to their home country, it was felt by the deaf sporting community that this was the 'chance of a lifetime to show the world what Britain's deaf athletes can do,'[52] and attempts were made to promote the Games to the

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[50] According to some reports, the German athletes carried their swastika emblazoned flag, which would have meant that it was the one time that this flag was flown on British soil. It is not clear whether this actually happened.
[51] Grant, Brian, *The Deaf Advance*, (1990), p. 147.
[52] *Deaf Quarterly News*, (April-June 1935), p. 3.

wider public, as well as the deaf community. *The British Deaf Sportsman*, exhorted those deaf who were 'too old for competition', to take annual holidays in August and go to London in order to cheer on the British team.[53] National newspapers carried stories about the games, and Lord Lonsdale made an appeal for assistance with costs to the general public in *The Manchester Guardian*.

> The one thing they can enjoy as well as a hearing person is sport, and for this reason their enthusiasm for sport in general and the games in particular is remarkable.[54]

The London games were held from August 17th to 24th, 1935 and 300 competitors took part.[55] Proceedings were held in various locations around London, the athletic events at the White City Stadium, the swimming competition in the Empire Pool, Wembley and the tennis tournament at the Chiswick Tennis Club. Although the Games was heralded as a great success for both Britain and deaf sport in general, the goodwill that seemed to permeate them was not evident prior to the event. There were clashes with British able-bodied sporting organisations when deaf sport did not adhere uncompromisingly to the rules.[56] The football event was threatened by withdrawal of official recognition because the matches would be held outside the official football season, which did not

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[53] *The British Deaf Sportsman*, Vol. 1, No. 6, (April-June, 1935), p .2. This journal only appears for a very short time, from May 1934 to September 1935, so it can be presumed that it was borne out of an added enthusiasm for sport leading up to the 1935 Deaf Games.
[54] The appeal appeared within the sporting pages. *The Manchester Guardian*, (May 31, 1935).
[55] *The Teacher of the Deaf*, Vol. XXXIII, (October 1935), p. 152.
[56] *Deaf Quarterly News*, (April -June 1935), p. 2.

begin until August 31st.[57] The Football Association sent the British Deaf Amateur Sports Association a letter early in 1935 warning them that any player or team who was not affiliated to the Football Association had to receive permission from the FA to play. If this permission was not granted and the matches were played without this authority, they could not be held under the Association's jurisdiction.[58] Football was no the only event under threat. Apparently the Empire Pool was difficult to secure for the swimming event, so the Brighton Pool was offered as an alternative. This was vetoed because it was salt-water, which meant that any world records that may be broken would not count.[59] Originally, the Queens Club was the suggested venue for tennis, but again the request was turned down. Despite these early problems, sites were located for all of the events and the games were heralded as a great success both from the organisational and athletic point of view.

The first day of the Games was mainly socialising and then on the Sunday, a Mass was held at St Paul's Cathedral which one thousand people attended.'[60] The Games began in earnest on the following day. Although these Games were conducted in a spirit of friendly rivalry, the British deaf athletics team had trained seriously. Deaf members of the Amateur Athletics Association were allowed to train at the White City, and for an investment of 6d a visit or 7s 6d for a season

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[57] *The British Deaf Times*, Vol. XXXIII, No. 377-378, (May-June, 1935), p. 66.
[58] *The British Deaf Sportsman*, Vol. 1, No. 2, (January-March, 1935), p. 9.
[59] *The British Deaf Times*, Vol. XXXIII, No. 377-378, (May-June, 1935), p. 66.
[60] McLoughlin, The *History of the Education of the Deaf*, (1987), p. 121.

ticket, they could use the track and borrow equipment for training purposes.[61] The results were mixed. One participant broke the world record in the men's 800 metres, the team performed well in the tennis tournament and were placed in the swimming. Football was also another British success.[62] Although preliminary matches were held at the Civil Sports Club, the final of the football tournament was played at the Arsenal stadium and the manager of the Arsenal Football Club, George Allison presented the trophy to the victorious team.[63] At the close of competition, the British team was second to the German in the overall points table. One of the reports from the Games stated a strong impression was 'the immense sense of national pride possessed by the Germans.'[64] All this suggests that as in able-bodied sport, the international deaf games was also bound up with questions of national prestige.

The position of some influential hearing people made the organising of the games more professional and less fraught with difficulty. Lord Lonsdale's newspaper appeal has already been mentioned, and other notables included Lord Aberdare, the Chairman of the Games Committee, Sir Noel Curtis-Bennett, who was a leading member of the British Olympic Association. Bennett had the Stadium Club and its accommodation opened for free use of the athletes for the week.[65]

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[61] *The British Deaf Sportsman*, Vol. 1, No. 1, (May-June 1934), p. 7.
[62] Britain beat Belgium 4-2. *The Teacher of the Deaf*, Vol. XXXIII, (October 1935), p. 154.
[63] *Deaf Quarterly News*, (October-December, 1935), p. 7.
[64] *The Teacher of the Deaf*, Vol. XXXIII, (October 1935), p. 155.
[65] Ibid. p. 152.

In 1939, a group of British athletes arrived in Stockholm in August for the Fifth International games for the Deaf. Following the usual round of these amateur competitions, the deaf team members were sent collecting sheets where friends and family would contribute a certain sum of money for their fares.[66] In 1939 their European rivals outclassed them; and the only events in which Britain emerged victorious were the tennis and the football.[67]

As well as the Games what was virtually a deaf Olympics, international tournaments began to be held in several different sports throughout the 1930s. Due to their geographical proximity, most of the competitions that Britain was invited to regularly were in France and Belgium. For example, as early as 1930 tennis tournaments were established between the three countries.[68] The first fully international tennis tournament for the deaf was held in 1938 in Prague and football tournaments were played regularly between clubs from France and London in the 1930s.

As well as taking part in their own games, deaf athletes also competed successfully in able-bodied sports, an option that was usually closed to those with other forms of disability. In Scotland, a young man called John Hogg won the sprint, 220 yards, high jump and the long jump and was placed in the relay in

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[66] Details of this in the announcement of the Games. *Deaf Quarterly News*, (July-September 1939), p. 11.
[67] The team had much more excitement on their way home when they were caught in the blockades of the Second World War. *Deaf Quarterly News*, (October-December 1939), p. 6.
[68] *The British Deaf Times*, Vol. XXVII, No. 319-320, (July-August 1930), p. 87.

the Scotland Olympic Club's sports in Glasgow in 1933. He was helped by a friend who waved a white handkerchief when the starter pistol was fired.[69] Teams as well as individuals entered the ranks of able-bodied sport. Many of the Deaf Clubs in London played in able-bodied competitions, for example, *The British Deaf Times* proudly reported that at the end of 1935, the East London Deaf Club was fourth in the West Ham Churches football league.[70] Men were not the only ones to enjoy the pleasure of games in a local league. A group of deaf women in Newcastle formed a hockey team and played in an able-bodied tournament. The report in the *Deaf Quarterly News* noted that, 'we have yet to register our first win, but we have stuck to it and enjoy the weekly games.'[71]

Other deaf people achieved national success in able-bodied sport. A young deaf man, William Redmond was signed as a professional with the football club Wolverhampton Wanderers.[72] While he did not achieve fame as a football player there was one who undoubtedly did. Cliff Bastin was not born deaf, but began to lose his hearing in 1936. He played first for Exeter City and was signed by Arsenal and was the youngest man at that time to be chosen to play international football for England. Bastin had to use all of his ingenuity in order to succeed. Although his autobiography does not mention him using any formalised sign language, a man who watched Bastin play in the 1930s remembered his relationship with his goal-scoring partner Alex James.

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[69] *The British Deaf Times*, Vol. XXX, No. 355-356, (July-Aug 1933), p. 93.
[70] *The British Deaf Times*, Vol. XXXIII, No. 387-388, (March-April, 1936), p. 43.
[71] *Deaf Quarterly News*, (January- March, 1937), p. 27.
[72] *Deaf Quarterly News*, (January-March, 1934), p. 5.

I had the good fortune to watch the James/Bastin partnership and noticed the sign language they used on the field. It was not the same as the Deaf use but it was clearly understood. When James made some sign Bastin was in the right position to receive the ball and score.[73]

More interestingly, Bastin downplayed his deafness while he was playing football, although he later felt it had a detrimental affect on his career.

> Had it not been for my hearing trouble, I feel confident that I would have managed to keep my England place right throughout the war.[74]

Although many deaf people exchanged their sporting clothes and recreation time for overalls and fire watching when war broke out in 1939, there was still a little time left over for some less life threatening activities. [75] Indoor sports such as billiards, snooker and darts were favoured over outdoor games, and some clubs continued their pre-war competitions. Some of the deaf schools that were not evacuated continued to hold their sports days during the war, for instance, the Yorkshire Institute for the Deaf and Dumb held their sports day in July 1940.

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[73] Dimmock, *British Deaf News*, (April 1997), p. 7.
[74] Cliff Bastin, *Cliff Bastin Remembers*, (London, 1950), p. 151.
[75] Reports on any sporting activities are very sparse in The British Deaf Times, space instead being devoted to employment issues and wartime assistance for the deaf. See *British Deaf Times*, Vol. XLI, 489-490, (September-October, 1944), p. 100.

Internationally, sporting connections for deaf people were also resumed very quickly, following a meeting of Comite International des Sports Silencieux in Paris in 1946. Since national sport had been put on hold in Britain during the war, the British representative at the conference resented the Committee requesting that the British association pay its affiliation fees for the war years. The British representative remarked in his report,

> I objected on principle to our having to pay for the war years and explained that we were too busy winning the war to spare time for sport.[76]

Deaf people began to re-establish their organised clubs immediately following V.E Day. Many of these were attached to social clubs and together they formed an important part of the community life of the deaf. As well as these more casual organisations, more competitive formalised structures soon reasserted themselves. The British Deaf Amateur Sports Association was re-established in 1946, and laid out its plans for the future.

> They include sports facilities for women as well as men, coaching and training facilities for promising athletes, a complete Indoor Games section, and a scheme whereby young athletes will be invited to participate in adult games during their final year at School.[77]

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[76] *The British Deaf Times*, Vol. XLIII, No. 513-514, (September-October, 1946), p. 96.
[77] *The British Deaf Times*, Vol. VLIII, No 511-512, (July-August, 1946), p. 69.

As well as the return to sporting clubs within Britain, correspondence between international deaf communities recommenced soon after the war. In 1945 the Union Deaf Club received a letter from a representative of the Deaf and Dumb Sportsmen of Belgium, congratulating the English for their part in winning the war, and reporting on the activities of Belgian sportsmen. They also asked whether the British could send them eight footballs as their equipment was pre-war vintage and due to the popularity of the game they were 'sorely in need of new balls.'[78]

Although the organisers of sport for deaf people were planning their next international games, the able-bodied held the first major post-war sporting event. In 1948, the year of the first post-war able-bodied Olympics and the first Stoke Mandeville Games, a deaf person achieved recognition in the able-bodied Games held in London. Although there were no deaf athletes in the British Olympic team, a deaf artist was awarded a gold medal. A.R. Thomson, who was also a member of the Royal Academy, won an Olympic gold medal in the Art Competition for his depiction of a 'Seated Boxer'.[79]

The first post war international sports meeting for the deaf was held only one year after the able-bodied Olympics had been staged in London. The 6th

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[78] There is no evidence that the request was met. *The British Deaf Times*, Vol. XLII, No. 501-502, (September-October, 1945), p. 96.
[79] Unfortunately he was not there to collect his prize because he was on a sailing holiday, so the deaf were denied their official public moment of glory. Dimmock, 'Sport and Deaf People (Britain)', in Taylor & Bishop, *Being Deaf*, (1991), p. 193.

Olympiad held in Copenhagen, Denmark in 1949 was a successful one for British deaf athletes, who had been selected for entry at a national meeting in London in June. Not only did 1949 herald a new post war decade in deaf sport but the competition organisers also changed the title of the Games, officially naming them the 'Olympiad'.[80] As in the able-bodied Olympics, neither the Germans nor the Japanese were allowed to participate. The renaming of the Games and the exclusion of the defeated nations were clear signs that the deaf were keen to mirror developments that were taking place in the able bodied sporting world. By taking such steps they sought to further legitimise their organisation within a wider non-deaf context. The removal of Germany, previously a strong competitor, gave Britain a chance to improve its overall standings. The twenty-one British athletes performed well; they were the winners in the Men's Singles and Doubles tennis, the 96-kilometre cycling road race and for the fifth time, holders of the football championship.[81] The British football team defeated Belgium 6-4, after suffering some injuries to their players from rough play in their early matches.[82] Men were not the only successful athletes. Miss E Horngold broke the world record in the 100-metre sprint at Copenhagen to conclude a triumphant competition for British deaf athletes.[83]

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[80] While initially there were no protests from the IOC, they decreed after the 1965 Games that the word 'Olympiad' must not be used unless it referred particularly to the able-bodied Olympics. Jackson, *Britain's Deaf Heritage*, (1990), p. 316.
[81] Ibid., p. 313.
[82] The Italians were accused of rough play. For a report see *The British Deaf Times*, Vol. XLVLL< No. 549-550, (September-October 1949), p. 92.
[83] Jackson, *Britain's Deaf Heritage*, (1990), p. 313.

> We have become so accustomed to the inevitable 'inquest' after every big international sporting event recently – poor old Britain, no stamina, no steaks, no calories, no vitamins, no good – that it is rather refreshing to have to record a few victories for a change.[84]

While the athletes had been successful, they continued to be beset by financial problems with travel costs and subsistence. Fortunately, the Deaf and Dumb Association had contributed the sizeable sum of £200.[85] For many years, however, international representative sport for deaf people was constantly threatened by a lack of money. By 1957, in order to meet the costs of the expected fifty competitors at the Games in Milan, the BDASA pledged to raise £3,000.[86] At the 1961 Olympiad, the British team complained that it was difficult to find alcohol and that meals at the Olympic village had to be paid for by the individual. For competitors from some countries, this was more than they had bargained for.

> The Turkish competitors were under the impression that accommodation and meals at the Olympic Village were free. When they learned that this had to be paid for they immediately left for home.[87]

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[84] *Deaf Quarterly News*, No. 179, (October-December, 1949), p. 8.
[85] *Deaf Quarterly News*, No. 179, (October-December, 1949), p. 8.
[86] *The British Deaf News*, Vol. 1, No. 11, (September-October, 1956), p. 317.
[87] *The British Deaf News*, Vol. 3, No. 7, (September, 1961), p. 160.

As noted earlier, the British government appointed a Sports Council in 1965. The first grant that it provided was one to the British Sports Association for the Disabled, which was headed by Ludwig Guttmann. Such funding demonstrated how effective Guttmann had been in locating himself as the prime mover in disabled sport, despite his late arrival on the field particularly when compared with the organisation of deaf games. Deaf sports did not receive any central government funding for the development of its activities, as it was not affiliated to BSAD, the only body that the government recognised. All it secured was occasional one off payments, such as that in 1966 of £500 to assist in paying the costs of the International Games for the Deaf in the United States.[88]

International competition continued in 1953 when the Seventh Deaf Olympiad was held in Brussels. The Games Committee in Brussels set out to emulate the Olympics in scope as well as name. Included with the usual round of sporting events, there was an Artistic and Literary Manifestation held for the first time.[89] This competition was broad and divided into two sections. The first one dealt with art in its broadest sense, and included anything from sculpture to 'journalism and publicity'.[90] The second part was dedicated to art and sport, and recognised any medium to promote it. This artistic competition was expanded in 1957 at the Milan Games. Advertising for the Italian Games in 1957 were decorated with a photograph of the five-ringed Olympic flag, which proved how seriously the deaf

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[88] *The British Deaf Times*, Vol. 5, No. 4, (Summer, 1966), p. 161.
[89] *Deaf News*, No. 193, (July-August 1952), p. 12.
[90] *Deaf News*, No. 193, (July-August 1952), p. 12.

took their games and were likened to their own version of the Olympics, which interestingly brought no protest from the IOC.[91] Many other Olympic traditions were followed, including the opening ceremony, the march past of nations and the release of birds.[92]

Deaf people took their international representation seriously and throughout the 1950s, used the national championships held every year to find the best athletes for the Deaf Olympics. A junior championship was introduced in 1950, principally to provide opportunities for the younger generation and to help the selectors of the international games to scrutinise new talent.[93] There was consternation, for example, when the times posted for the National Swimming Championships in 1957 were not of a sufficiently high standard.

> ...It must be noted that the times recorded did not approach international level and in most cases showed a considerable difference on the wrong side.[94]

The results in 1957 mirrored those of Cold War able-bodied sport, with the United States dominating certain sports like basketball, and the USSR reigning supreme

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[91] It must be borne in mind that these competitions were smaller and badly publicised outside journals for deaf people.
[92] In this case, pigeons were released not doves as in the able-bodied Games. *The British Deaf Times*, Vol. LI, No. 597-598, (September-October, 1953), p. 72.
[93] *The Deaf Quarterly News*, No. 182, (July –September, 1950), p. 18.
[94] *The British Deaf News*, Vol. 2, No. 2, (April-June 1957) p.37.

in the athletics events, especially the women's competition.[95] The U.S.A. increased their delegation of some 5 or 6 athletes to 42.[96] Cold War politics were also eventually part of the deaf sporting world as Russia registered their disapproval when the United States was voted the location for the Games of 1965. In this, deaf sport echoed developments in able-bodied sport whereby both the superpowers devoted much time and energy to improving their sporting performance as part of the Cold War struggle.

Although the British were concerned about their low standard in sport, they were still holding on to the amateur ideal that there was something not entirely proper about high levels of competitiveness. Another example of the European competitive commitment in sporting events was evident at the Third World Congress for the Deaf, which was held in Germany. The delegates were treated to an exhibition of European sporting prowess on the track.

> Not until the event was over did they allow themselves to relax from the determination of their effort. It may not be the typical Britishers' idea of "enjoying" his sport, but, by hokey, it wins events and will certainly be much in evidence at Helsinki![97]

As the number of countries competing in deaf sport increased, Britain retired into

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[95] *The British Deaf News*, Vol. 2, No. 4, (October-December, 1957), p. 82.

[96] *The British Deaf News*, Vol. 2, No. 4, (October-December, 1957), p. 80.

[97] *The British Deaf News*, Vol. 2, No. 12, (no month, 1959), p. 270.

the world of the small nations.

> A British team will be hard pressed to match the performances of the big battalions, but in these games at least, Baron Coubertin's wish on the revival of Olympic contests in 1896, that taking part should be more important than winning, will still be very much in the contestants' minds, unlike the real Olympics which carry ever-increasing national prestige for the winners of contests which are supposedly between individuals and not sovereign states.[98]

In the 1960s, international sports like the deaf Olympiad had larger numbers of competitors and were well-established enough to be in large capacity venues. Like the International Stoke Mandeville Games in 1960, the 1961 Olympiad was held in the Olympic stadium built for the 1952 able-bodied event at Helsinki. The report of the BDASA claimed that some of the results from the Helsinki Games were comparable to those of contemporary able-bodied sporting achievements. But an examination of the times posted for individual events illustrates that the results differ, with times for the deaf significantly slower than those of the able-bodied. For instance, the record at the Deaf Olympiad for the Men's 100 metres in 1961 was 12 seconds whereas the able-bodied time for the same event at the Olympics in 1960 was 10.2 seconds.[99]

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[98] *The British Deaf News*, Vol. 4, No. 10, (Summer 1965), p. 281.
[99] *Chronicle of the Olympics*, (1998), p. 265.

Like other disabled groups, deaf people tried to find heroes with whom they could identify. If a deaf person was famous, and had succeeded in the hearing world, then the person was lauded, and used as an inspiration and role model for all deaf people. This was especially useful in the case of sporting stars. Even if they were not British, their careers were followed in the deaf press, for example, when a Belgian, Frans Callaerts came to London to fight British boxer Terence Murphy, in 1955 there was great interest from the deaf press because Callaerts was deaf.[100] The fact that he lost the fight was not deemed to be so important. Deaf people closely followed the career of an Italian boxer named Marion D'Agata, as he was not only deaf, but was a champion bantamweight. D'Agata did not hide his disability, and allowances were made for the fact that he could not hear the bell.[101] Even if an athlete played in another country, or was a foreigner like D'Agata deaf people who were interested in sport would know their name. Another example of this was a Scottish member of the Milan rugby club who wore a hearing aid.[102]

Another famous sportsman, who had the notoriety of being deaf, was Lester Piggott. Crowned champion jockey eleven times, he was diagnosed as hard of hearing when he was eight years old. Piggott's deafness, although not profound, was sufficient enough for him to be featured in deaf journals, and deaf people

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[100] *The British Deaf News*, Vol. 1, No. 3, (May-June 1955), p. 84.
[101] The referee arranged certain types of signals with D'Agata, so that he would be aware of when a round had finished, or the progress of a count when a boxer had been knocked down. *The British Deaf News*, Vol. 6, No. 5, (June 1968), p. 167.
[102] *The British Deaf News*, Vol. 2, No. 8, (October-December, 1958), p. 178.

placed more emphasis of his deafness than Piggott did. 'Lester's slight deafness probably contributes a good deal to his shy reserve, often wrongly dismissed as off-handedness.'[103] Piggott, however, did not necessarily agree with the sweeping generalisations regarding his deafness.

> Over the years plenty of people have tried to make out that my hearing disability caused me all sorts of psychological problems – it turned me in on myself they said, and made me feel isolated – but for me it was much more straightforward: simply something that had to be overcome.[104]

Like Guttmann at Stoke Mandeville, deaf people compared themselves with hearing people and lauded those who were successful, especially in the field of sporting endeavour.

> In almost every branch of physical prowess there are outstanding deaf men or women who can hold their own in competition with the hearing.[105]

These included not only the famous, like Lester Piggott but also many not so well known, such as C.W. Coulman who, in 1956, was placed third in the 7-Mile Walk at White City.[106]

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[103] *The British Deaf News*, Vol. 4, No. 10, (Summer 1965), p. 281.
[104] L. Piggott, *Lester: The Autobiography of Lester Piggott*, (London, 1995), p. 7.
[105] *The British Deaf News*, Vol. 1, No. 9, (May-June, 1956), p. 279.
[106] *The British Deaf News*, Vol. 1, No. 9, (May-June, 1956), p. 279.

While there was quite obviously a predisposition towards international sport for the few in many of the deaf journals, as well as an interest in famous deaf sports people, what were the many ordinary deaf people doing for their recreation? Generally, schools for deaf children offered a similar curriculum to able-bodied schools, as well as providing their own particular slant, for instance part of the certificate of 'General Usefulness' at the Royal School for Deaf and Dumb Children was for both boys and girls to 'swim a distance'.[107] Physical exercises were practised every morning at Homerton especially when the school was moved to a holiday location, where swimming and rambles were also part of the round of lessons.[108] Students attending the Mary Hare Grammar School had physical training lessons in PT and games, the girls played lacrosse and netball with games of football and cricket for the boys.[109] As we have seen, football was a popular recreational activity for deaf people and it was also played in schools. The boys from the Yorkshire Residential School for the Deaf played in the able-bodied Doncaster and District Schoolboys Football League, and matches between the school and able-bodied schools in the district continued throughout the 1960s.[110]

Many deaf people enjoyed the physical and social aspects of sport, which included activities such as rambling and games and were prepared to establish

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[107] Beaver, *A Tower of Strength*, (1992), p. 138.
[108] The school holiday was held in 1906, 1914 and 1919. Woodford, *Homerton 1900-1921*, (1998), pp. 23-26.
[109] *The Silent World*, Vol. 1 No. 1, (June 1946), p. 16.
[110] Anthony J. Boyce, *The History of the Yorkshire Residential School for the Deaf 1829-1979*, (Doncaster, 1999), p. 66.

their own venues in order to participate in them, for example the St John of Beverley Club laid down their own hard tennis court at their own expense.[111] The Adult Deaf and Dumb Institute rented five acres at Alexandra Park from 1936 and members enjoyed building the necessary equipment, such as a pavilion and a lawn, playing croquet and cricket in the summer and football and hockey in the winter.[112] As well as the outdoor variety, deaf people played a five a side football regional competition throughout the late 1960s and early 1970s. The Central Council of Physical Recreation was involved with this sporting competition as they provided the referees. They certainly earned their fee as they had to continually warn players at the Welsh Regional Competition in 1970 for foul play.[113]

Deaf people also took part in the expansion of outdoor pursuits in the late 1960s and 1970s. Like the able-bodied, they entered the Duke of Edinburgh's Award Scheme during the 1960s, and many were involved in the orienteering, camping and walking tests that led to the Award.[114] The British Deaf and Dumb held their first outdoor summer school at the Lake District where the group tried new activities such as rock-climbing, hiking and canoeing. Like blind people, deaf people were provided with opportunities to enjoy activities such as gliding and skiing.

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[111] *The Silent World*, (August 1924), p. 5.
[112] *The Manchester Guardian*, (June 2nd, 1936).
[113] *The British Deaf News*, Vol. 7, No. 7, (June, 1970), p. 214.
[114] *The British Deaf News*, Vol. 7, No. 7, (June, 1970), p. 214.

As we have explained earlier, spectating was an important part of the sporting experience and deaf people were no different to others. From the 1950s, television was a way for many people to watch sport all over the world. Sports programmes were not signed, but as a visual medium watching sport was enjoyable for deaf people.[115]

The separation from other disabled groups was signalled most forcefully by their organisation of their own events at an international level from a very early stage. It had no military background in physical training or a history born out of a rehabilitation centre for the deaf. Sport for deaf people has never combined with any other disabled sport, nor have deaf people participated in any disabled games other than their own. Yet it is clear that sport played a very important role in the lives of some deaf people, especially the young. Sport, be it within the able bodied world, or as part of the large and long standing deaf sports network, gave deaf people an opportunity for competitive contest. By examining the history of deaf sport, it has been possible to show the deaf community facing in two ways: towards the able-bodied and towards the main groups of disabled people. Sporting isolation continued from the disabled even with the advent of the Stoke Mandeville Games, and later Multi-hetero international games, both of which they were excluded though indeed they had not sought to gain admittance.

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[115] Television was the subject of some controversy in 1956 when the Australian test cricketers were warned that what they said on television could be lip-read by deaf cricket fans. Apparently, a new camera called 'Our Big Bill', provided a much clearer close-up than previously and the cricketers were warned that since they could now be seen so clearly that they had to ensure that their language was suitable to be broadcast to the thousands of viewers. *The British Deaf News*, Vol. 1, No. 9, (May-June 1956), p. 275.

Although such segregation was costly to deaf sport in terms of government funding, as they did not join BSAD, their independence allowed them to develop both their own international sporting competition and also for the exceptional few, participate in able-bodied sport.

Despite the emphasis on sport by certain sections of the deaf community, their role as a disabled group was seen as being much more important. The report of the Seventh Olympiad in 1957 was sidelined in the *Deaf News* for a more consequential report on the World Congress for the Deaf, eventually appearing in a later issue. Although it is clear that physical therapy and exercise were highly important to the rehabilitation of disabled people, this was not the case for deaf people. Sport was not a part of a medical scheme of rehabilitation for deaf people but was early taken up for its own values and virtues. Into the 1950s, the deaf continued to keep their sport separate from the developing world of other disabled sports. While the Stoke Mandeville Games celebrated its 'internationalisation' in 1952 with the arrival and participation of six athletes from the Netherlands, the deaf were secure in the knowledge that they had long been staging multi-faceted international sports, with a complex organising structure. But despite their international games, deaf people were in an ambivalent position. They did not embrace the developments that were taking place elsewhere within the disabled sporting world, and they regularly applauded those of their number who broke through into able-bodied sport. The numbers of deaf people who competed in able-bodied sport at both the elite professional and

amateur level, is testament to the fact that deafness, while clearly a disability that created profound difficulties, did not exclude people from being physically active. Effectively the deaf kept their sport in a perpetual limbo, which emulated the ideals and virtues of the able-bodied, and shunned other disabled sporting groups preserving their own separate organisation. Such sporting separatism as pursued by the deaf also sat uneasily with their political position, which remained very much with the disabled as a whole. Rather than concentrating specifically on deaf issues, as happened in their sport, most of the journals for deaf people reported on the issues which concerned all types of disabled people. Improvements for deaf people thanks to new legislation were followed avidly by readers of the deaf press. Although in sports the deaf had segregated themselves from other forms of disability – in other spheres such as employment and social welfare, they were firmly part of the disabled.

Conclusion

The thesis contends with three main themes and attempts to understand them in the broader context of social and medical history. Firstly the thesis attempts to trace the development of remedial exercise, and how it changed over time from rather simple drill to a much more complicated and systematic process. Secondly, the work traces the progress of organised disabled sport that came as a result of this therapy and examines in what ways it affected each different disabled group. Thirdly, the work examines exercise and sport as representative of the history of disabled people. For instance, was the provision of sport and remedial therapy geared toward any particular disabled group and how did this reflect the treatment of disabled people generally?

After the First World War, the numbers of disabled people increased dramatically. However, these were not young children, who needed both physical and moral guidance, but were young, previously fit men who had suffered the disastrous impact of war. With no experience of how to reintegrate them into society, the disabled soldier returning from the war relied on both government assistance and different charities established for his benefit. An entire Ministry was set up in order to deal with pensions and assistance for disabled ex-servicemen. Associations such as St Dunstan's were an early example not only of the assistance that the disabled soldier would receive, but also their preferential treatment in relation to other disabled people that would last for many years. One of the ways that a disabled soldier could return to his normal life was

to enjoy the pastimes and recreations that he had practised before the war. As these were young fit men, often one of their previous enjoyments had been sport. So sport was introduced for these disabled ex-servicemen, not so much to improve their morale and physical standard, as it was with children, but in order to provide them with something familiar to fall back on. The sports developed competitively, either at different associations, like St Dunstan's, or at individual hospitals like Roehampton.

From the outset, it was clear that drill and physical exercise were considered important. Not just by those practising medicine, but also by the government in its pursuit of a healthier population. Prescribing physical exercise was also a less expensive way for government to give the impression that they were concerned for the health of the nation. Although they continued to have a laissez faire attitude, and blamed the health of the nation on the individual's own inability to care for himself, government did try to organise some form of exercise therapy for both the able-bodied and the disabled. For the disabled, physical exercise played an important role in therapy. The main recipients of this therapy were disabled children.

The influx of permanently wounded soldiers after the First World War compelled state intervention. After the First World War was over, what the thesis has termed the 'hierarchy of disability' was established and became the blueprint of how disabled people would be treated throughout the remainder of the period

covered by the thesis. The war disabled were the top group, with welfare and assistance that eclipsed any previous State efforts on their behalf. Not only did this manifest itself through State aid, but also within the voluntary sector, there were societies and workshops where disabled ex-servicemen could find employment. Even in the realm of recreation, disabled ex-servicemen fared better. Societies such as St Dunstan's organised competitions, provided equipment such as boats for rowing on Regent's Park Lake, and ensured that as many of the members were as active as possible. This was probably much more easily accomplished with groups of reasonably well fed, fit ex-servicemen than it was with groups of undernourished tired children, and so the war wounded continued to receive the most sympathy and fiscal support. All of the other disabled groups were marginalised in favour of the war disabled. At the 1920 conference on the Care and Cure of Crippled Children, it was remarked that this provision for the war disabled had caused 'an appalling amount of suffering' amongst other disabled people.[1] The group that followed, at a considerable distance, the war disabled, were those people who had been injured in industry. Before the Second World War, certain employers such as mining companies were pressured by unions and provided remedial exercises and re-training for those injured at work. The National Insurance Scheme was ostensibly established to provide support for a worker who was injured, but this did not hold true for a person who was so disabled that they were not able to work, which brings us to the third group. The civilian disabled had to rely mainly on the efforts of voluntary agencies and charities. There was little physical therapy available

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[1] *Report of the Central Committee for the Care of Cripples*, (London, 1921), p. 18.

for these more unfortunate disabled people, although children who attended school were to be made fit through drill and physical exercise. Disabled children generally fell into the last category, although as the century progressed, they were supplied with some government help through the School Medical Service and then especially during the Second World War and after the establishment of the welfare state. While some would argue that the advent of the welfare state ensured that there was adequate treatment for everybody, and no doubt the situation for disabled people was improved markedly, ex-servicemen continued to have priority over all groups of disabled people. However, disabled people did not simply acquiesce in this treatment of them as was evident from this letter from 1946.

> You boast of social security, you make 'security from the cradle to the grave' your proud slogan and all the time you ignore thousands of British citizens. You pay pensions to the ex-service invalids, God bless them, you give industrial casualties their just do; old folk receive a rightful reward for a lifetime of hard work, when the ordinary wear and tear of life proves too much for them; if one is 'lucky' enough to be blind instead of crippled a compassionate government grants a pension, but what of the civilian cripple, who is incapable of earning a living?[2]

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[2] *National Cripples Joumal*, No. 64, (1946), p. 6.

Throughout the 1950s the preferential treatment for the ex-servicemen continued. Their supporters in parliament saw to it that they continued to have more resources than any other group. Even when there was no new additional funding for disabled people, pensions for the war wounded were still increasing, and the disabled ex-servicemen used their position to strike and march on Downing Street in the 1950s when they were dissatisfied with their lot. It was not until the middle of the 1960s that the civilian disabled began agitating for some equality in their level of support, and the thesis ends with the successful outcome of their campaigning: the passing of the Chronically Sick and Disabled Persons Act (1970).

It was not really until the Second World War broke out that the fitness of disabled civilians became a government concern, although disabled people had been exercising socially through their own disabled societies. There was no altruistic reason for this change, but more because disabled people were needed as workers in order to meet the demand for labour. There were also more disabled people returning from the war as the advent of drugs and innovative treatment ensured that many more people survived serious injury.

In the late 1930s the term rehabilitation was coined, which became the most important development in physical medicine during the 1940s. This word came to mean not only the medical restoration of a person, but included their physical, mental and social well being. Much of the physical wellbeing included special

remedial exercises and the role of physiotherapy developed in importance. Recognition and support from medical practitioners ensured that physiotherapy had an important place in the process of rehabilitation. Rehabilitation was used primarily to return wounded servicemen back to the war, but for those more seriously injured, rehabilitation meant that those with residual disability might continue to help the war effort. In 1944, these theories of rehabilitation were used on the previously most difficult of all disabled groups, the spinal paralysed at the Spinal Unit at Stoke Mandeville. Exercise and other competitive activities were applied to this group with outstanding results. Not only was the exercise therapy successful, it progressed to competitive games that then grew to an official competition by 1949. It is important to note that the Stoke Mandeville Games were driven both by Guttmann and the war disabled patients.

Organised sport by disabled people was a by-product of the rehabilitation process. The most important result of a period of rehabilitation was the prospect of employment. After the Second World War was over, the government took over much of the rehabilitation provision, reducing that of the Forces and increasing the work of the Ministry of Labour and National Service. Although remedial exercises and sport were important in centres such as Stoke Mandeville, their main purpose was to rehabilitate the paralysed person and then work with the various government employees in order that jobs may be procured. In this, the State's purpose was threefold; it was able to control numbers in the workforce, by ensuring that training courses were offered where there was a

shortage of jobs, to control the spending on welfare, and to provide people to help reduce the post war labour shortage.

Although Stoke Mandeville was supposed to be finding its patients jobs, it was hardly a model rehabilitation centre. Guttmann was obviously more interested in sport than jobs and the Stoke Mandeville Games continued to be held throughout the 1950s and 1960s. It grew in scope, both with increased numbers of international competitors and the growth in the varied sports that were played. Developments we see today, such as the classification system and rules for different sports are a product of those early games. Many disabled sporting groups previously had been made up of ex-servicemen, and they continued to dominate disabled sport throughout the 1950s. While those in wheelchairs at Stoke Mandeville expanded their sport, other disabled people were gradually forming their own sporting organisations throughout the 1960s. It was not until 1961 that the formation of BSAD attempted to bring organised competitive games under one banner. Yet disabled sport was still rife with segregation, especially between those in wheelchairs who attended the Stoke Mandeville Games, and other disabled groups, like the blind and amputees. This separation was maintained partly because those representatives from Stoke Mandeville dominated the organisation. By the end of the 1960s, the government became involved in funding disabled sport through BSAD, albeit on a very small scale

Stoke Mandeville was one of the most important developments within the history of organised sport for disabled people. But a truly integrated highly organised international competition for the physically disabled would not manifest itself until the 1980s. Sport and games developed at differing rates for all disabled people as is evident from the thesis. While blind people appeared to have had a buoyant and lively sporting competition from the 1920s, particularly at institutions like St Dunstan's, they did not join in any kind of official competitions until the 1960s. Deaf people never joined with the majority of disabled people in sport. Due to the lack of any outward signs of disability, those who had suffered hearing loss or who were born deaf remained within their own special group. Sport did not have to be adapted for deaf people in the same way that it did for those in wheelchairs, so deaf people played sport against the able bodied as Cliff Bastin did, or, ignoring other disabled groups altogether, held their own Silent Sports. The remarkable thing about the deaf was not only that they held their own sporting competition, but they established their own international sporting organisation in 1924, only 28 years after the first modern Olympics was held.

While there was no doubt that games and sport were played for therapeutic reasons, and were vital to the regime of rehabilitation from the 1940s onwards, by the end of the 1960s physical activity had split from its rehabilitative origins, although there was, and still remains some connection between the two. There were complaints levelled by the 1960s at the government and the media that wheelchair sport, despite its international representation was still not considered

sport. This mirrored disabled people's call for more equal treatment in other spheres as well.

This thesis has attempted to trace the origins of physical therapy and sport in the twentieth century and then contextualise it within disabled people's history. What this study also demonstrates is the need for more work on disabled people, their experiences and their history. As well as concentrating on histories which focus on disabled people's history within any given period of time, work should be undertaken to ensure that disabled people feature as part of the overall historical picture. A study of the welfare state should not be considered complete unless the story of disabled people is woven into the text. This study has been an early attempt to rectify the way history and historians have largely ignored an important ten percent of the British population.

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- SA/BMA British Medical Association - Files C.507, C.509, f.98.
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Appendix 1

List of Key Events and Committees

1888 – Invalid Children's Aid Association established
1893 – Elementary Education (Blind and Deaf) Act
1899 - Elementary Education (Defective and Epileptic Children) Act
1914 – Establishment of the National Institute for the Blind
1915 – St Dunstan's opened
1915 – Queen Mary's at Roehampton opened
1916 – Ministry of Pensions established
1916 – Star and Garter Home opened
1919 – Central Council for the Care of Cripples formed
1919 – King's National Roll established
1920 – Dawson Report
1920 – Blind Person's Act
1921 – Education Act
1921 – British Legion established
1923 – National Institute for the Deaf formed
1924 – first Deaf international Silent Games
1932 – Formation of British Limbless Ex-Servicemen's Association
1937 – Workers Compensation Act
1937 – Physical Training and Recreation Act
1939 – Delevingne Committee's Final Report
1942 – Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons established.
1944 – Disabled Persons (Employment) Act
1944 – opening of Stoke Mandeville
1945 – Remploy established
1945 – British Council for Rehabilitation formed
1946 – National Assistance Act
1946 – First Report of the Standing Committee of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons
1946 – formation of the British Council for the Welfare of Spastics
1948 – Invalid Tricycle Association created
1948 – first Stoke Mandeville Games
1949 – Second Report of the Standing Committee of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons
1950 – numbers registered under the Disabled Persons (Employment) Act peaks at 900,000.
1951 – British Epilepsy Association formed
1952 – Nathan Committee on Charity report
1952 – Spastics Society established
1953 – Ministry of Pensions closed
1953 – Formation of Multiple Sclerosis Society
1954 – Muscular Dystrophy Group formed
1958 - Final Report of the Standing Committee of the Inter-departmental Committee on the Rehabilitation and Resettlement of Disabled Persons also known as the Piercy Committee
1960 – Stoke Mandeville Games held at the able-bodied venue in Rome
1961 – British Sport Association for the Disabled formed

1962 – first Commonwealth Games for Paraplegics in Perth, Australia
1964 – McCorquodale Report
1965 – Disablement Income Group established
1965 – Sports Council formed
1967 – Action by families of children affected by Thalidomide was settled after commencing in 1962.
1967 – Abortion Act
1969 – Disablement Income Group Petition to parliament demanding national income for disabled people
1970 – Chronically Sick and Disabled Persons Act legislated